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

Delete everything after the enacting clause and insert:

"ARTICLE 1

DISABILITY SERVICES

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

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

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

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

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

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

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

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

~~(3)~~ (4) the amount necessary to increase the aid payment schedule for school district aids and credits payments in section 127A.45 to not more than 90 percent rounded to the

nearest tenth of a percent without exceeding the amount available and with any remaining funds deposited in the budget reserve;

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

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

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

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

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

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

Subdivision 1. **Long-term care access fund established.** A long-term care access fund is created in the state treasury. The fund is a direct appropriated special revenue fund. The commissioner shall deposit to the credit of the fund money made available to the fund. Notwithstanding section 11A.20, all investment income and all investment losses attributable

3.1 to the investment of the long-term care access fund not currently needed shall be credited
3.2 to the long-term care access fund.

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

3.10 Subd. 3. **Allocation of contribution amount.** If on the basis of a forecast of general
3.11 fund revenues and expenditures the commissioner of management and budget determines
3.12 that there will be a positive unrestricted budgetary general fund balance at the close of the
3.13 biennium and that there will be a long-term care access fund contribution amount at the end
3.14 of the biennium, the commissioner of management and budget must transfer the contribution
3.15 amount to the long-term care access fund in accordance with the requirements of section
3.16 16A.152.

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

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

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

3.30 (b) Financial contributions by the state to the Home Care Orientation Trust shall be made
3.31 by the state pursuant to a collective bargaining agreement negotiated under this section. All
3.32 such financial contributions by the state shall be held in trust for the purpose of paying,
3.33 from principal, from income, or from both, the costs associated with developing, delivering,
3.34 and promoting voluntary orientation training for individual providers of direct support

4.1 services working under a collective bargaining agreement and providing services through
4.2 a covered program under section 256B.0711. The Home Care Orientation Trust shall be
4.3 administered, managed, and otherwise controlled jointly by a board of trustees composed
4.4 of an equal number of trustees appointed by the state and trustees appointed by the exclusive
4.5 representative under this section, and the trust shall not be an agent of either the state or of
4.6 the exclusive representative.

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

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

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

4.18 Sec. 5. Minnesota Statutes 2022, section 245A.11, subdivision 7, is amended to read:

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

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

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

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

5.1 individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart
5.2 19, if required.

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

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

5.11 (d) ~~A variance granted by the commissioner according to this subdivision before January~~
5.12 ~~1, 2014, to a license holder for an adult foster care home must transfer with the license when~~
5.13 ~~the license converts to a community residential setting license under chapter 245D. The~~
5.14 ~~terms and conditions of the variance remain in effect as approved at the time the variance~~
5.15 ~~was granted~~ The variance requirements under this subdivision for alternative overnight
5.16 supervision do not apply to community residential settings licensed under chapter 245D.

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

5.18 Sec. 6. Minnesota Statutes 2022, section 245A.11, subdivision 7a, is amended to read:

5.19 Subd. 7a. **Alternate overnight supervision technology; adult foster care ~~and~~**
5.20 **~~community residential setting~~ licenses.** (a) The commissioner may grant an applicant or
5.21 license holder an adult foster care ~~or community residential setting~~ license for a residence
5.22 that does not have a caregiver in the residence during normal sleeping hours as required
5.23 under Minnesota Rules, part 9555.5105, subpart 37, item B, or section 245D.02, subdivision
5.24 33b, but uses monitoring technology to alert the license holder when an incident occurs that
5.25 may jeopardize the health, safety, or rights of a foster care recipient. The applicant or license
5.26 holder must comply with all other requirements under Minnesota Rules, parts 9555.5105
5.27 to 9555.6265, or applicable requirements under chapter 245D, and the requirements under
5.28 this subdivision. The license printed by the commissioner must state in bold and large font:

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

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

5.32 (b) Applications for a license under this section must be submitted directly to the
5.33 Department of Human Services licensing division. The licensing division must immediately

6.1 notify the county licensing agency. The licensing division must collaborate with the county
6.2 licensing agency in the review of the application and the licensing of the program.

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

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

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

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

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

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

6.20 (i) a description of the triggering incident;

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

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

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

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

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

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

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

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

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

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

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

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

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

7.26 (iv) each resident's individualized plan of care, support plan under sections 256B.0913,
7.27 subdivision 8; 256B.092, subdivision 1b; 256B.49, subdivision 15; and 256S.10, if required,
7.28 or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart
7.29 19, if required, identifies the maximum response time, which may be greater than ten minutes,
7.30 for the license holder to be on site for that resident.

7.31 (f) Each resident's placement agreement, individual service agreement, and plan must
7.32 clearly state that the adult foster care ~~or community residential setting~~ license category is
7.33 a program without the presence of a caregiver in the residence during normal sleeping hours;

8.1 the protocols in place for responding to situations that present a serious risk to the health,
8.2 safety, or rights of residents served by the program under paragraph (e), clause (1) or (2);
8.3 and a signed informed consent from each resident served by the program or the person's
8.4 legal representative documenting the person's or legal representative's agreement with
8.5 placement in the program. If electronic monitoring technology is used in the home, the
8.6 informed consent form must also explain the following:

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

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

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

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

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

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

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

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

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

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

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

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

9.7 (l) To be eligible for a license under paragraph (a), the adult foster care ~~or community~~
9.8 ~~residential setting~~ license holder must not have had a conditional license issued under section
9.9 245A.06 or any licensing sanction under section 245A.07 during the prior 24 months based
9.10 on failure to provide adequate supervision, health care services, or resident safety in the
9.11 adult foster care home ~~or community residential setting~~.

9.12 (m) The commissioner shall review an application for an alternative overnight supervision
9.13 license within 60 days of receipt of the application. When the commissioner receives an
9.14 application that is incomplete because the applicant failed to submit required documents or
9.15 that is substantially deficient because the documents submitted do not meet licensing
9.16 requirements, the commissioner shall provide the applicant written notice that the application
9.17 is incomplete or substantially deficient. In the written notice to the applicant, the
9.18 commissioner shall identify documents that are missing or deficient and give the applicant
9.19 45 days to resubmit a second application that is substantially complete. An applicant's failure
9.20 to submit a substantially complete application after receiving notice from the commissioner
9.21 is a basis for license denial under section 245A.05. The commissioner shall complete
9.22 subsequent review within 30 days.

9.23 (n) Once the application is considered complete under paragraph (m), the commissioner
9.24 will approve or deny an application for an alternative overnight supervision license within
9.25 60 days.

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

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

9.29 (2) the presence of a caregiver or direct support staff in a residence during normal sleeping
9.30 hours, unless a determination has been made and documented in the individual's support
9.31 plan that the individual does not require the presence of a caregiver or direct support staff
9.32 during normal sleeping hours.

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

10.1 Sec. 7. **[245D.261] COMMUNITY RESIDENTIAL SETTINGS; REMOTE**
10.2 **OVERNIGHT SUPERVISION.**

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

10.5 (b) "Enabling technology" means a device capable of live, two-way communication or
10.6 engagement between a resident and direct support staff at a remote location.

10.7 (c) "Monitoring technology" means the use of equipment to oversee, monitor, and
10.8 supervise someone who receives medical assistance waiver or alternative care services
10.9 under chapter 256B or 256S.

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

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

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

10.19 (1) use enabling technology;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.1 Sec. 8. **[256.4761] PROVIDER CAPACITY GRANTS FOR RURAL AND**
12.2 **UNDERSERVED COMMUNITIES.**

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

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

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

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

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

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

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

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

12.26 (1) expanding existing services;

12.27 (2) increasing access in rural or underserved areas;

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

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

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

13.1 Sec. 9. **[256.4762] SUPPORTING NEW AMERICANS IN THE LONG-TERM CARE**
13.2 **WORKFORCE GRANTS.**

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

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

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

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

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

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

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

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

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

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

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

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

13.31 (i) course fees;

14.1 (ii) child care costs;

14.2 (iii) transportation costs;

14.3 (iv) tuition fees;

14.4 (v) financial coaching fees; or

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

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

14.9 Sec. 10. **[256.4763] AWARENESS-BUILDING CAMPAIGN FOR THE**
14.10 **RECRUITMENT OF DIRECT CARE PROFESSIONALS.**

14.11 Subdivision 1. **Grant program established.** The commissioner of employment and
14.12 economic development shall develop and implement paid advertising as part of a
14.13 comprehensive awareness-building campaign aimed at recruiting direct care professionals
14.14 to provide long-term care services.

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

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

14.21 (b) Grant funds received under this section may be used for the following:

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

14.24 (i) television;

14.25 (ii) streaming services;

14.26 (iii) radio;

14.27 (iv) social media;

14.28 (v) billboards; and

14.29 (vi) other print materials;

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

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

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

15.6 The Department of Employment and Economic Development may collaborate with relevant
15.7 state agencies for the purposes of the development and implementation of this campaign
15.8 and is authorized to transfer administrative funding to such agencies to cover any associated
15.9 administrative costs.

15.10 Sec. 11. **[256.4764] HOME AND COMMUNITY-BASED WORKFORCE**
15.11 **INCENTIVE FUND GRANTS.**

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

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

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

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

15.20 (1) a provider of home and community-based services under Minnesota Statutes, chapter
15.21 245D; or

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

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

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

15.28 (1) retention, recruitment, and incentive payments;

15.29 (2) postsecondary loan and tuition payments;

15.30 (3) child care costs;

16.1 (4) transportation-related costs; and

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

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

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

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

16.11 (1) the employer is an eligible employer;

16.12 (2) the total number of eligible employees;

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

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

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

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

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

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

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

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

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

16.29 Subd. 6. **Grants not to be considered income.** (a) For the purposes of this subdivision,
16.30 "subtraction" has the meaning given in Minnesota Statutes, section 290.0132, subdivision

17.1 1, paragraph (a), and the rules in that subdivision apply to this subdivision. The definitions
17.2 in Minnesota Statutes, section 290.01, apply to this subdivision.

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

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

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

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

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

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

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

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

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

17.20 Sec. 12. **[256.4771] SUPPORTED-DECISION-MAKING PROGRAMS.**

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

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

17.26 (b) "Supported decision making" has the meaning given in section 524.5-102, subdivision
17.27 16a.

17.28 (c) "Supported-decision-making services" means services provided to help an individual
17.29 consider, access, or develop supported decision making, potentially as an alternative to
17.30 more restrictive forms of decision making, including guardianship and conservatorship.
17.31 The services may be provided to the individual, family members, or trusted support people.

18.1 The individual may currently be a person subject to guardianship or conservatorship, but
18.2 the services must not be used to help a person access a guardianship or conservatorship.

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

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

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

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

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

18.13 Subd. 4. **Evaluation and report.** By June 30, 2024, and every two years after that, the
18.14 commissioner must submit to the chairs and ranking minority members of the legislative
18.15 committees with jurisdiction over human services a report on the impact and outcomes of
18.16 the grants to supported-decision-making programs, including any available evidence of
18.17 increased utilization of supported-decision-making and of reductions in more restrictive
18.18 forms of decision making. The report must also detail how the funding was used to achieve
18.19 the requirements in subdivision 3, paragraph (b).

18.20 Subd. 5. **Applications.** Any public or private nonprofit agency may apply to the
18.21 commissioner for a grant under subdivision 3, paragraph (a), clause (1) or (3). Any county
18.22 or Tribal agency in Minnesota may apply to the commissioner for a grant under subdivision
18.23 3, paragraph (a), clause (2). The application must be submitted in a form approved by the
18.24 commissioner.

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

18.28 Sec. 13. Minnesota Statutes 2022, section 256B.0659, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

20.1 (j) "Managing employee" has the same definition as Code of Federal Regulations, title
20.2 42, section 455.

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

20.5 (l) "Personal care assistance provider agency" means a medical assistance enrolled
20.6 provider that provides or assists with providing personal care assistance services and includes
20.7 a personal care assistance provider organization, personal care assistance choice agency,
20.8 class A licensed nursing agency, and Medicare-certified home health agency.

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

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

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

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

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

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

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

20.27 Sec. 14. Minnesota Statutes 2022, section 256B.0659, subdivision 12, is amended to read:

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

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

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

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

(2) provider name and telephone numbers;

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

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

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

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

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

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

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

Sec. 15. Minnesota Statutes 2022, section 256B.0659, subdivision 19, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23.19 Sec. 16. Minnesota Statutes 2022, section 256B.0659, subdivision 24, is amended to read:

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

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

23.24 (2) comply with general medical assistance coverage requirements;

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

23.27 (4) comply with background study requirements;

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

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

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

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

24.6 (9) document that the agency uses a minimum of 72.5 percent of the revenue generated
24.7 by the medical assistance rate for personal care assistance services for employee personal
24.8 care assistant wages and benefits. The revenue generated by the qualified professional and
24.9 the reasonable costs associated with the qualified professional shall not be used in making
24.10 this calculation;

24.11 (10) make the arrangements and pay unemployment insurance, taxes, workers'
24.12 compensation, liability insurance, and other benefits, if any;

24.13 (11) enter into a written agreement under subdivision 20 before services are provided;

24.14 (12) report suspected neglect and abuse to the common entry point according to section
24.15 256B.0651;

24.16 (13) provide the recipient with a copy of the home care bill of rights at start of service;

24.17 (14) request reassessments at least 60 days prior to the end of the current authorization
24.18 for personal care assistance services, on forms provided by the commissioner;

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

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

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

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

25.1 Sec. 17. Minnesota Statutes 2022, section 256B.0911, subdivision 13, is amended to read:

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

25.5 (b) MnCHOICES certified assessors must:

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

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

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

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

25.16 Sec. 18. Minnesota Statutes 2022, section 256B.0949, subdivision 15, is amended to read:

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

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

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

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

25.30 (1) have at least 2,000 hours of supervised clinical experience or training in examining
25.31 or treating people with ASD or a related condition or equivalent documented coursework
25.32 at the graduate level by an accredited university in ASD diagnostics, ASD developmental

26.1 and behavioral treatment strategies, and typical child development or an equivalent
26.2 combination of documented coursework or hours of experience; and

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

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

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

26.11 (iii) a board-certified behavior analyst; or

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

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

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

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

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

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

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

26.31 (2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28.1 Sec. 19. Minnesota Statutes 2022, section 256B.4911, is amended by adding a subdivision
28.2 to read:

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

28.8 (1) alternative care program;

28.9 (2) brain injury waiver;

28.10 (3) community alternative care waiver;

28.11 (4) community access for disability inclusion waiver;

28.12 (5) developmental disabilities waiver;

28.13 (6) elderly waiver; and

28.14 (7) Minnesota senior health option.

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

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

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

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

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

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

29.1 Sec. 20. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision
29.2 to read:

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

29.6 (1) home and community-based services for seniors under chapter 256S and section
29.7 256B.0913, home and community-based services for people with developmental disabilities
29.8 under section 256B.092, and home and community-based services for people with disabilities
29.9 under section 256B.49;

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

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

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

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

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

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

30.4 Sec. 21. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision
30.5 to read:

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

30.9 Sec. 22. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision
30.10 to read:

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

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

30.19 Sec. 23. Minnesota Statutes 2022, section 256B.4914, subdivision 3, is amended to read:

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

30.24 (1) 24-hour customized living;

30.25 (2) adult day services;

30.26 (3) adult day services bath;

30.27 (4) community residential services;

30.28 (5) customized living;

30.29 (6) day support services;

30.30 (7) employment development services;

31.1 (8) employment exploration services;

31.2 (9) employment support services;

31.3 (10) family residential services;

31.4 (11) individualized home supports;

31.5 (12) individualized home supports with family training;

31.6 (13) individualized home supports with training;

31.7 (14) integrated community supports;

31.8 (15) night supervision;

31.9 (16) positive support services;

31.10 (17) prevocational services;

31.11 (18) residential support services;

31.12 (19) ~~respite services;~~

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

31.14 ~~(21)~~ (20) other services as approved by the federal government in the state home and
31.15 community-based services waiver plan.

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

31.19 Sec. 24. Minnesota Statutes 2022, section 256B.4914, subdivision 4, is amended to read:

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

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

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

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

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

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

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

(9) service hours provided through monitoring technology.

(d) Updates to individual data must include:

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

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 2022, section 256B.4914, subdivision 5, is amended to read:

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2022, section 256B.4914, subdivision 5a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35.23 (17) for night supervision staff, 40 percent of the median wage for home health and
35.24 personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant
35.25 (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code
35.26 29-2053); and 20 percent of the median wage for social and human services aide (SOC code
35.27 21-1093)~~; and~~.

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

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

36.1 Sec. 27. Minnesota Statutes 2022, section 256B.4914, subdivision 5b, is amended to read:

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

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

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

36.11 ~~(3)~~ (2) on ~~July~~ January 1, ~~2026~~ 2024, and every two years thereafter, by the percentage
36.12 change in the CPI-U from the date of the previous update to the data available ~~30~~ 12 months
36.13 and one day prior to the scheduled update.

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

36.17 Sec. 28. Minnesota Statutes 2022, section 256B.4914, subdivision 5c, is amended to read:

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

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

36.25 Sec. 29. Minnesota Statutes 2022, section 256B.4914, subdivision 5d, is amended to read:

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

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

37.4 Sec. 30. Minnesota Statutes 2022, section 256B.4914, subdivision 5e, is amended to read:

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

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

37.12 (1) wages and salaries;

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

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

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

37.21 (c) Compensation-related costs for persons employed in the central office of a corporation
37.22 or entity that has an ownership interest in the provider or exercises control over the provider,
37.23 or for persons paid by the provider under a management contract, do not count toward the
37.24 80 percent requirement under this subdivision.

37.25 (d) A provider agency or individual provider that receives a rate subject to the
37.26 requirements of this subdivision shall prepare, and upon request submit to the commissioner,
37.27 a distribution plan that specifies the amount of money the provider expects to receive that
37.28 is subject to the requirements of this subdivision, including how that money was or will be
37.29 distributed to increase compensation-related costs for employees. Within 60 days of final
37.30 implementation of a rate adjustment subject to the requirements of this subdivision, the
37.31 provider must post the distribution plan and leave it posted for a period of at least six months
37.32 in an area of the provider's operation to which all direct support professionals have access.
37.33 The posted distribution plan must include instructions regarding how to contact the

38.1 commissioner or commissioner's representative if an employee believes the employee has
38.2 not received the compensation-related increase described in the plan.

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

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

38.7 Sec. 31. Minnesota Statutes 2022, section 256B.4914, is amended by adding a subdivision
38.8 to read:

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

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

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

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

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

38.23 Sec. 32. Minnesota Statutes 2022, section 256B.4914, subdivision 8, is amended to read:

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

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

38.31 (1) competitive workforce factor: 4.7 percent;

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

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

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

39.4 (5) program plan support ratio: 15.5 percent;

39.5 (6) client programming and support ratio: 4.7 percent, updated as specified in subdivision
39.6 5b;

39.7 (7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

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

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

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

Sec. 33. Minnesota Statutes 2022, section 256B.4914, subdivision 9, is amended to read:

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

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

41.4 (5) program plan support ratio: 7.0 percent;

41.5 (6) client programming and support ratio: 2.3 percent, updated as specified in subdivision
41.6 5b;

41.7 (7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42.5 (11) this is the subtotal rate;

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

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

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

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

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

42.18 Sec. 34. Minnesota Statutes 2022, section 256B.4914, subdivision 10, is amended to read:

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

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

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

42.26 (3) the distinct underlying costs for services provided by a license holder under sections
42.27 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
42.28 by a license holder certified under section 245D.33.

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

(1) values for transportation rates;

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

(3) values for indirect services;

(4) values for nursing;

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

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

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

(8) direct care workforce labor market measures;

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

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

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

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

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

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

Sec. 35. Minnesota Statutes 2022, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to ~~9a~~ 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified

44.1 in subdivision 17, a provider enrolled to provide services with rates determined under this
44.2 section must submit requested cost data to the commissioner to support research on the cost
44.3 of providing services that have rates determined by the disability waiver rates system.
44.4 Requested cost data may include, but is not limited to:

44.5 (1) worker wage costs;

44.6 (2) benefits paid;

44.7 (3) supervisor wage costs;

44.8 (4) executive wage costs;

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

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

44.11 (7) administrative costs paid;

44.12 (8) program costs paid;

44.13 (9) transportation costs paid;

44.14 (10) vacancy rates; and

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

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

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

44.28 (d) The commissioner shall analyze cost data submitted under paragraph (a) and, in
44.29 consultation with stakeholders identified in subdivision 17, may submit recommendations
44.30 on component values and inflationary factor adjustments to the chairs and ranking minority
44.31 members of the legislative committees with jurisdiction over human services once every

four years beginning January 1, 2021. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (c).

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

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

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

Sec. 36. Minnesota Statutes 2022, section 256B.4914, subdivision 10c, is amended to read:

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

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

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

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

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

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

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

46.1 Sec. 37. Minnesota Statutes 2022, section 256B.4914, subdivision 12, is amended to read:

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

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

46.8 (1) the person has a developmental disability and:

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

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

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

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

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

46.26 Sec. 38. Minnesota Statutes 2022, section 256B.4914, subdivision 14, is amended to read:

46.27 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies
46.28 must identify individuals with exceptional needs that cannot be met under the disability
46.29 waiver rate system. The commissioner shall use that information to evaluate and, if necessary,
46.30 approve an alternative payment rate for those individuals. Whether granted, denied, or
46.31 modified, the commissioner shall respond to all exception requests in writing. The

47.1 commissioner shall include in the written response the basis for the action and provide
47.2 notification of the right to appeal under paragraph (h).

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

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

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

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

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

47.14 (d) Exception requests must include the following information:

47.15 (1) the service needs required by each individual that are not accounted for in subdivisions
47.16 6 to ~~9a~~ 9;

47.17 (2) the service rate requested and the difference from the rate determined in subdivisions
47.18 6 to ~~9a~~ 9;

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

47.21 (4) any contingencies for approval.

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

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

47.31 (g) The commissioner shall determine whether to approve or deny an exception request
47.32 no more than 30 days after receiving the request. If the commissioner denies the request,

48.1 the commissioner shall notify the lead agency and the individual disability waiver recipient,
48.2 the interested party, and the license holder in writing of the reasons for the denial.

48.3 (h) The individual disability waiver recipient may appeal any denial of an exception
48.4 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
48.5 256.0451. When the denial of an exception request results in the proposed demission of a
48.6 waiver recipient from a residential or day habilitation program, the commissioner shall issue
48.7 a temporary stay of demission, when requested by the disability waiver recipient, consistent
48.8 with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary
48.9 stay shall remain in effect until the lead agency can provide an informed choice of
48.10 appropriate, alternative services to the disability waiver.

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

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

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

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

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

48.25 Sec. 39. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision
48.26 to read:

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

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

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

49.4 Sec. 40. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision
49.5 to read:

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

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

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

49.14 Sec. 41. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision
49.15 to read:

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

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

49.21 (1) wages and salaries;

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

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

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

49.29 (c) Compensation-related costs for persons employed in the central office of a corporation
49.30 or entity that has an ownership interest in the provider or exercises control over the provider,

50.1 or for persons paid by the provider under a management contract, do not count toward the
50.2 80 percent requirement under this subdivision.

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

50.14 Sec. 42. Minnesota Statutes 2022, section 256B.85, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

51.1 (6) services provided by a consultation services provider as defined under subdivision
51.2 17, that is under contract with the department and enrolled as a Minnesota health care
51.3 program provider;

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

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

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

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

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

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

51.20 Sec. 43. Minnesota Statutes 2022, section 256B.85, is amended by adding a subdivision
51.21 to read:

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

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

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

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

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

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

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

52.11 Sec. 44. Minnesota Statutes 2022, section 256B.851, subdivision 5, is amended to read:

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

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

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

52.16 (3) employee benefits factor, 12.04 percent;

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

52.18 (5) program plan support factor, 7.00 percent;

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

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

52.21 (8) absence and utilization factor, 3.90 percent.

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

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

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

52.27 (3) qualified professional services and CFSS worker training and development: ~~75.45~~
52.28 88.19 percent.

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

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

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

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

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

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

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

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

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

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

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

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

53.29 Sec. 45. Minnesota Statutes 2022, section 256B.851, subdivision 6, is amended to read:

53.30 Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine
53.31 the rate for personal care assistance services, CFSS, extended personal care assistance
53.32 services, extended CFSS, enhanced rate personal care assistance services, enhanced rate

54.1 CFSS, qualified professional services, and CFSS worker training and development as
54.2 follows:

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

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

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

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

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

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

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

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

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

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

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

54.28 Sec. 46. Minnesota Statutes 2022, section 256S.2101, subdivision 1, is amended to read:

54.29 Subdivision 1. **Phase-in for disability waiver customized living rates.** All rates and
54.30 rate components for community access for disability inclusion customized living and brain
54.31 injury customized living under section 256B.4914 ~~shall~~ must be the sum of ~~ten~~ 21.6 percent

55.1 of the rates calculated under sections 256S.211 to 256S.215 and ~~90~~ 78.4 percent of the rates
55.2 calculated using the rate methodology in effect as of June 30, 2017.

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

55.6 Sec. 47. Minnesota Statutes 2022, section 289A.20, subdivision 4, is amended to read:

55.7 Subd. 4. **Sales and use tax.** (a) The taxes imposed by chapter 297A are due and payable
55.8 to the commissioner monthly on or before the 20th day of the month following the month
55.9 in which the taxable event occurred, or following another reporting period as the
55.10 commissioner prescribes or as allowed under section 289A.18, subdivision 4, paragraph (f)
55.11 or (g), except that use taxes due on an annual use tax return as provided under section
55.12 289A.11, subdivision 1, are payable by April 15 following the close of the calendar year.

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

55.16 (1) Two business days before June 30 of calendar year 2020 and 2021, the vendor must
55.17 remit 87.5 percent of the estimated June liability to the commissioner. Two business days
55.18 before June 30 of calendar year 2022 and thereafter, the vendor must remit 84.5 percent, or
55.19 a reduced percentage as certified by the commissioner under section 16A.152, subdivision
55.20 2, paragraph (a), clause ~~(6)~~ (7), of the estimated June liability to the commissioner.

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

55.23 (c) A vendor having a liability of:

55.24 (1) $10,000 or more, but less than $250,000, during a fiscal year must remit by electronic
55.25 means all liabilities on returns due for periods beginning in all subsequent calendar years
55.26 on or before the 20th day of the month following the month in which the taxable event
55.27 occurred, or on or before the 20th day of the month following the month in which the sale
55.28 is reported under section 289A.18, subdivision 4; or

55.29 (2) $250,000 or more during a fiscal year must remit by electronic means all liabilities
55.30 in the manner provided in paragraph (a) on returns due for periods beginning in the
55.31 subsequent calendar year, except that a vendor subject to the remittance requirements of
55.32 paragraph (b) must remit the percentage of the estimated June liability, as provided in

56.1 paragraph (b), clause (1), which is due two business days before June 30. The remaining
56.2 amount of the June liability is due on August 20.

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

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

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

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

56.15 (3) concrete, cement, and masonry.

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

56.18 Sec. 48. Minnesota Statutes 2022, section 289A.60, subdivision 15, is amended to read:

56.19 Subd. 15. **Accelerated payment of June sales tax liability; penalty for**
56.20 **underpayment.** (a) For payments made after December 31, 2019, and before December
56.21 31, 2021, if a vendor is required by law to submit an estimation of June sales tax liabilities
56.22 and 87.5 percent payment by a certain date, the vendor shall pay a penalty equal to ten
56.23 percent of the amount of actual June liability required to be paid in June less the amount
56.24 remitted in June. The penalty must not be imposed, however, if the amount remitted in June
56.25 equals the lesser of 87.5 percent of the preceding May's liability or 87.5 percent of the
56.26 average monthly liability for the previous calendar year.

56.27 (b) For payments made after December 31, 2021, the penalty must not be imposed if
56.28 the amount remitted in June equals the lesser of 84.5 percent, or a reduced percentage as
56.29 certified by the commissioner under section 16A.152, subdivision 2, paragraph (a), clause
56.30 ~~(6)~~ (7), of the preceding May's liability or 84.5 percent of the average monthly liability for
56.31 the previous calendar year.

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

57.3 Sec. 49. Laws 2021, First Special Session chapter 7, article 17, section 16, is amended to
57.4 read:

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

57.7 (a) This act includes $400,000 in fiscal year 2022 and $300,000 in fiscal year 2023 for
57.8 an actuarial research study of public and private financing options for long-term services
57.9 and supports reform to increase access across the state. Any unexpended amount in fiscal
57.10 year 2023 is available through June 30, 2024. The commissioner of human services must
57.11 conduct the study. Of this amount, the commissioner may transfer up to $100,000 to the
57.12 commissioner of commerce for costs related to the requirements of the study. The general
57.13 fund base included in this act for this purpose is $0 in fiscal year 2024 and $0 in fiscal year
57.14 2025.

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

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

57.17 Sec. 50. Laws 2021, First Special Session chapter 7, article 17, section 20, is amended to
57.18 read:

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

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

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

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

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

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

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

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

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

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

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

58.16 Sec. 51. **MEMORANDUMS OF UNDERSTANDING.**

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

58.20 Sec. 52. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

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

58.24 Sec. 53. **BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY**
58.25 **SUPPORTS.**

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

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

59.5 Sec. 54. **DIRECT CARE SERVICE CORPS PILOT PROJECT.**

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

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

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

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

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

59.28 Sec. 55. **EMERGENCY GRANT PROGRAM FOR AUTISM SPECTRUM**
59.29 **DISORDER TREATMENT AGENCIES.**

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

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

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

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

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

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

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

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

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

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

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

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

60.27 (1) the eligibility of the project;

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

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

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

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

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

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

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

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

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

61.12 (f) The commissioner shall award grants to eligible agencies through December 31,
61.13 2025.

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

61.16 Sec. 56. **RATE INCREASE FOR CERTAIN HOME CARE SERVICES.**

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

61.22 (b) Effective January 1, 2024, or upon federal approval, whichever is later, the
61.23 commissioner must increase payment rates for respiratory therapy under Minnesota Rules,
61.24 part 9505.0295, subpart 2, item E, and for home health services and home care nursing
61.25 services, except home health aide visits, under Minnesota Statutes, section 256B.0651,
61.26 subdivision 2, clauses (1) to (3), by 55 percent from the rates in effect on December 31,
61.27 2023. The commissioner must apply the annual rate increases under Minnesota Statutes,
61.28 sections 256B.0653, subdivision 8, and 256B.0654, subdivision 5, to the rates resulting
61.29 from the application of the rate increase under this paragraph.

62.1 Sec. 57. **SPECIALIZED EQUIPMENT AND SUPPLIES LIMIT INCREASE.**

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

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

62.8 Sec. 58. **STUDY TO EXPAND ACCESS TO SERVICES FOR PEOPLE WITH**
62.9 **CO-OCCURRING BEHAVIORAL HEALTH CONDITIONS AND DISABILITIES.**

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

62.16 Sec. 59. **TEMPORARY GRANT FOR SMALL CUSTOMIZED LIVING**
62.17 **PROVIDERS.**

62.18 The commissioner must establish a temporary grant for customized living providers that
62.19 serve six or fewer people in a single-family home and that are transitioning to a community
62.20 residential services licensure or integrated community supports licensure. Allowable uses
62.21 of grant money include physical plant updates required for community residential services
62.22 or integrated community supports licensure, technical assistance to adapt business models
62.23 and meet policy and regulatory guidance, and other uses approved by the commissioner.
62.24 License holders of eligible settings must apply for grant money using an application process
62.25 holders of eligible settings must apply for grant money using an application process
62.26 determined by the commissioner. Grant money approved by the commissioner is a onetime
62.27 award of up to $20,000 per eligible setting. To be considered for grant money, eligible
62.28 license holders must submit a grant application by June 30, 2024. The commissioner may
62.29 approve grant applications on a rolling basis.

63.1 Sec. 60. **DIRECTION TO COMMISSIONER; SUPPORTED-DECISION-MAKING**
63.2 **REIMBURSEMENT STUDY.**

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

63.17 Sec. 61. **DIRECTION TO COMMISSIONER; APPLICATION OF INTERMEDIATE**
63.18 **CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
63.19 **RATE INCREASES.**

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

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

63.23 (2) apply any required rate increase as required under Minnesota Statutes, section
63.24 256B.5012, subdivision 20, to the results of clause (1).

63.25 Sec. 62. **DIRECTION TO COMMISSIONER; SHARED SERVICES.**

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

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

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

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

64.7 (4) issue guidance for shared services, including:

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

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

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

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

64.16 (1) instructions for shared services support planning;

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

64.19 (3) required contents of shared services agreements.

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

64.22 Sec. 63. **DIRECTION TO COMMISSIONER; DISABILITY WAIVER SHARED**
64.23 **SERVICES RATES.**

64.24 The commissioner of human services shall establish a rate system for shared homemaker
64.25 services and shared chore services provided under Minnesota Statutes, sections 256B.092
64.26 and 256B.49. For two persons sharing services, the rate paid to a provider must not exceed
64.27 1-1/2 times the rate paid for serving a single individual, and for three persons sharing
64.28 services, the rate paid to a provider must not exceed two times the rate paid for serving a
64.29 single individual. These rates apply only when all of the criteria for the shared service have
64.30 been met.

65.1 Sec. 64. **DIRECTION TO COMMISSIONER; LIFE-SHARING SERVICES.**

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

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

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

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

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

65.16 (3) disability advocacy organizations; and

65.17 (4) lead agencies.

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

65.21 (c) The commissioner must provide a method for the commissioner and interested
65.22 stakeholders to cofacilitate public meetings. The first meeting must occur before January
65.23 31, 2023. The commissioner must host the cofacilitated meetings at least monthly through
65.24 December 31, 2023. All meetings must be accessible to all interested stakeholders, recorded,
65.25 and posted online within one week of the meeting date.

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

65.29 (1) the distinction between life sharing and adult family foster care;

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

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

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

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

66.3 (6) potential medical assistance payment methodologies for life-sharing services;

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

66.5 (8) draft language for legislation necessary to define and implement life-sharing services.

66.6 Subd. 5. **Report to the legislature.** By December 31, 2024, the commissioner must
66.7 provide to the chairs and ranking minority members of the house of representatives and
66.8 senate committees and divisions with jurisdiction over direct care services a report
66.9 summarizing the discussions between the commissioner and the interested stakeholders and
66.10 the commissioner's recommendations. The report must also include any draft legislation
66.11 necessary to define and implement life-sharing services.

66.12 Sec. 65. **REPEALER.**

66.13 Minnesota Statutes 2022, section 256B.4914, subdivision 9a, is repealed.

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

66.17 **ARTICLE 2**

66.18 **AGING SERVICES**

66.19 Section 1. Minnesota Statutes 2022, section 256.9754, is amended to read:

66.20 **256.9754 ~~COMMUNITY SERVICES DEVELOPMENT~~ LIVE WELL AT HOME**
66.21 **GRANTS ~~PROGRAM~~.**

66.22 Subdivision 1. **Definitions.** For purposes of this section, the following terms have the
66.23 meanings given.

66.24 (a) "Community" means a town, township, city, or targeted neighborhood within a city,
66.25 or a consortium of towns, townships, cities, or targeted neighborhoods within cities.

66.26 (b) "Core home and community-based services provider" means a Faith in Action, Living
66.27 at Home/Block Nurse, congregational nurse, or similar community-based program governed
66.28 by a board, the majority of whose members reside within the program's service area, that
66.29 organizes and uses volunteers and paid staff to deliver nonmedical services intended to

67.1 assist older adults to identify and manage risks and to maintain their community living and
67.2 integration in the community.

67.3 (c) "Long-term services and supports" means any service available under the elderly
67.4 waiver program or alternative care grant programs, nursing facility services, transportation
67.5 services, caregiver support and respite care services, and other home and community-based
67.6 services identified as necessary either to maintain lifestyle choices for older adults or to
67.7 support them to remain in their own home.

67.8 (b) (d) "Older adult services" means any services available under the elderly waiver
67.9 program or alternative care grant programs; nursing facility services; transportation services;
67.10 respite services; and other community-based services identified as necessary either to
67.11 maintain lifestyle choices for older Minnesotans, or to promote independence.

67.12 (c) (e) "Older adult" refers to individuals 65 years of age and older.

67.13 Subd. 2. **Creation; purpose.** (a) The community services development live well at home
67.14 grants program is are created under the administration of the commissioner of human
67.15 services.

67.16 (b) The purpose of projects selected by the commissioner of human services under this
67.17 section is to make strategic changes in the long-term services and supports system for older
67.18 adults and people with dementia including statewide capacity for local service development
67.19 and technical assistance, and statewide availability of home and community-based services
67.20 for older adult services, caregiver support and respite care services, and other supports in
67.21 the state of Minnesota. These projects are intended to create incentives for new and expanded
67.22 home and community-based services in Minnesota in order to:

67.23 (1) reach older adults early in the progression of their need for long-term services and
67.24 supports, providing them with low-cost, high-impact services that will prevent or delay the
67.25 use of more costly services;

67.26 (2) support older adults to live in the most integrated, least restrictive community setting;

67.27 (3) support the informal caregivers of older adults;

67.28 (4) develop and implement strategies to integrate long-term services and supports with
67.29 health care services, in order to improve the quality of care and enhance the quality of life
67.30 of older adults and their informal caregivers;

67.31 (5) ensure cost-effective use of financial and human resources;

68.1 (6) build community-based approaches and community commitment to delivering
68.2 long-term services and supports for older adults in their own homes;

68.3 (7) achieve a broad awareness and use of lower-cost in-home services as an alternative
68.4 to nursing homes and other residential services;

68.5 (8) strengthen and develop additional home and community-based services and
68.6 alternatives to nursing homes and other residential services; and

68.7 (9) strengthen programs that use volunteers.

68.8 (c) The services provided by these projects are available to older adults who are eligible
68.9 for medical assistance and the elderly waiver under chapter 256S, the alternative care
68.10 program under section 256B.0913, or the essential community supports grant under section
68.11 256B.0922, and to persons who have their own funds to pay for services.

68.12 Subd. 3. ~~**Provision of**~~ **Community services development grants.** The commissioner
68.13 shall make community services development grants available to communities, providers of
68.14 older adult services ~~identified in subdivision 1~~, or to a consortium of providers of older
68.15 adult services, to establish older adult services. Grants may be provided for capital and other
68.16 costs including, but not limited to, start-up and training costs, equipment, and supplies
68.17 related to older adult services or other residential or service alternatives to nursing facility
68.18 care. Grants may also be made to renovate current buildings, provide transportation services,
68.19 fund programs that would allow older adults or individuals with a disability to stay in their
68.20 own homes by sharing a home, fund programs that coordinate and manage formal and
68.21 informal services to older adults in their homes to enable them to live as independently as
68.22 possible in their own homes as an alternative to nursing home care, or expand state-funded
68.23 programs in the area.

68.24 Subd. 3a. **Priority for other grants.** The commissioner of health shall give priority to
68.25 a grantee selected under subdivision 3 when awarding technology-related grants, if the
68.26 grantee is using technology as part of the proposal unless that priority conflicts with existing
68.27 state or federal guidance related to grant awards by the Department of Health. The
68.28 commissioner of transportation shall give priority to a grantee under subdivision 3 when
68.29 distributing transportation-related funds to create transportation options for older adults
68.30 unless that preference conflicts with existing state or federal guidance related to grant awards
68.31 by the Department of Transportation.

68.32 Subd. 3b. **State waivers.** The commissioner of health may waive applicable state laws
68.33 and rules for grantees under subdivision 3 on a time-limited basis if the commissioner of

69.1 health determines that a participating grantee requires a waiver in order to achieve
69.2 demonstration project goals.

69.3 Subd. 3c. **Caregiver support and respite care projects.** (a) The commissioner shall
69.4 establish projects to expand the availability of caregiver support and respite care services
69.5 for family and other caregivers. The commissioner shall use a request for proposals to select
69.6 nonprofit entities to administer the projects. Projects shall:

69.7 (1) establish a local coordinated network of volunteer and paid respite workers;

69.8 (2) coordinate assignment of respite care services to caregivers of older adults;

69.9 (3) assure the health and safety of the older adults;

69.10 (4) identify at-risk caregivers;

69.11 (5) provide information, education, and training for caregivers in the designated
69.12 community; and

69.13 (6) demonstrate the need in the proposed service area, particularly where nursing facility
69.14 closures have occurred or are occurring or areas with service needs identified by section
69.15 144A.351. Preference must be given for projects that reach underserved populations.

69.16 (b) Projects must clearly describe:

69.17 (1) how they will achieve their purpose;

69.18 (2) the process for recruiting, training, and retraining volunteers; and

69.19 (3) a plan to promote the project in the designated community, including outreach to
69.20 persons needing the services.

69.21 (c) Funds for all projects under this subdivision may be used to:

69.22 (1) hire a coordinator to develop a coordinated network of volunteer and paid respite
69.23 care services and assign workers to clients;

69.24 (2) recruit and train volunteer providers;

69.25 (3) provide information, training, and education to caregivers;

69.26 (4) advertise the availability of the caregiver support and respite care project; and

69.27 (5) purchase equipment to maintain a system of assigning workers to clients.

69.28 (d) Volunteer and caregiver training must include resources on how to support an
69.29 individual with dementia.

69.30 (e) Project funds may not be used to supplant existing funding sources.

70.1 Subd. 3d. **Core home and community-based services projects.** The commissioner
70.2 shall select and contract with core home and community-based services providers for projects
70.3 to provide services and supports to older adults both with and without family and other
70.4 informal caregivers using a request for proposals process. Projects must:

70.5 (1) have a credible public or private nonprofit sponsor providing ongoing financial
70.6 support;

70.7 (2) have a specific, clearly defined geographic service area;

70.8 (3) use a practice framework designed to identify high-risk older adults and help them
70.9 take action to better manage their chronic conditions and maintain their community living;

70.10 (4) have a team approach to coordination and care, ensuring that the older adult
70.11 participants, their families, and the formal and informal providers are all part of planning
70.12 and providing services;

70.13 (5) provide information, support services, homemaking services, counseling, and training
70.14 for the older adults and family caregivers;

70.15 (6) encourage service area or neighborhood residents and local organizations to
70.16 collaborate in meeting the needs of older adults in their geographic service areas;

70.17 (7) recruit, train, and direct the use of volunteers to provide informal services and other
70.18 appropriate support to older adults and their caregivers; and

70.19 (8) provide coordination and management of formal and informal services to older adults
70.20 and their families using less expensive alternatives.

70.21 Subd. 3e. **Community service grants.** The commissioner shall award contracts for
70.22 grants to public and private nonprofit agencies to establish services that strengthen a
70.23 community's ability to provide a system of home and community-based services for elderly
70.24 persons. The commissioner shall use a request for proposals process.

70.25 Subd. 3f. **Live well at home grants extension.** (a) A community or organization that
70.26 has previously received a grant under subdivision 3c, 3d, or 3e, that funded a project that
70.27 has proven to be successful and that is no longer eligible for funding under subdivision 3c,
70.28 3d, or 3e, may apply to the commissioner to receive ongoing funding to sustain the project.

70.29 (b) In order to be eligible for a grant under this subdivision, a grant applicant must:

70.30 (1) have an operating budget of $300,000 or less;

70.31 (2) provide home and community-based services that fill a service gap in a designated
70.32 geographic area; or

71.1 (3) be the only provider of essential community services such as chore services,
71.2 homemaker services, or transportation in a designated geographic area.

71.3 (c) The commissioner shall use a request for proposals process and may use a two-year
71.4 grant cycle.

71.5 Subd. 4. **Eligibility.** Grants may be awarded only to communities and providers or to a
71.6 consortium of providers that have a local match of 50 percent of the costs for the project in
71.7 the form of donations, local tax dollars, in-kind donations, fundraising, or other local matches.

71.8 Subd. 5. **Grant preference.** The commissioner of human services shall give preference
71.9 when awarding grants under this section to areas where nursing facility closures have
71.10 occurred or are occurring or areas with service needs identified by section 144A.351. The
71.11 commissioner may award grants to the extent grant funds are available and to the extent
71.12 applications are approved by the commissioner. Denial of approval of an application in one
71.13 year does not preclude submission of an application in a subsequent year. The maximum
71.14 grant amount is limited to $750,000.

71.15 Sec. 2. **[256.9756] CAREGIVER RESPITE SERVICES GRANTS.**

71.16 Subdivision 1. **Caregiver respite grant program established.** The commissioner of
71.17 human services must establish a caregiver respite services grant program to increase the
71.18 availability of respite services for family caregivers of people with dementia and older adults
71.19 and to provide information, education, and training to respite caregivers and volunteers
71.20 regarding caring for people with dementia. From the funds made available for this purpose,
71.21 the commissioner must award grants on a competitive basis to respite service providers,
71.22 giving priority to areas of the state where there is a high need of respite services.

71.23 Subd. 2. **Eligible uses.** Grant recipients awarded grant funding under this section must
71.24 use a portion of the grant award as determined by the commissioner to provide free or
71.25 subsidized respite services for family caregivers of people with dementia and older adults.

71.26 Subd. 3. **Report.** By January 15, 2026, and every other January 15 thereafter, the
71.27 commissioner shall submit a progress report about the caregiver respite services grants in
71.28 this section to the chairs and ranking minority members of the legislative committees and
71.29 divisions with jurisdiction over human services. The progress report must include metrics
71.30 of the use of the grant program funds.

72.1 Sec. 3. Minnesota Statutes 2022, section 256B.0913, subdivision 4, is amended to read:

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

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

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

72.10 (3) the person is age 65 or older;

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

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

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

72.19 (7) except for individuals described in clause (8), the monthly cost of the alternative
72.20 care services funded by the program for this person does not exceed 75 percent of the
72.21 monthly limit described under section 256S.18. This monthly limit does not prohibit the
72.22 alternative care client from payment for additional services, but in no case may the cost of
72.23 additional services purchased under this section exceed the difference between the client's
72.24 monthly service limit defined under section 256S.04, and the alternative care program
72.25 monthly service limit defined in this paragraph. If care-related supplies and equipment or
72.26 environmental modifications and adaptations are or will be purchased for an alternative
72.27 care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive
72.28 months beginning with the month of purchase. If the monthly cost of a recipient's other
72.29 alternative care services exceeds the monthly limit established in this paragraph, the annual
72.30 cost of the alternative care services shall be determined. In this event, the annual cost of
72.31 alternative care services shall not exceed 12 times the monthly limit described in this
72.32 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

74.1 approved elderly waiver plan and delivered from the date the individual was found eligible
74.2 for the federally approved elderly waiver plan. Notwithstanding this provision, alternative
74.3 care funds may not be used to pay for any service the cost of which: (i) is payable by medical
74.4 assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a
74.5 medical assistance income spenddown for a person who is eligible to participate in the
74.6 federally approved elderly waiver program under the special income standard provision.

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

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

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

74.18 Sec. 4. Minnesota Statutes 2022, section 256B.0913, subdivision 5, is amended to read:

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

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

74.22 (2) home care;

74.23 (3) homemaker services;

74.24 (4) personal care;

74.25 (5) case management and conversion case management;

74.26 (6) respite care;

74.27 (7) specialized supplies and equipment;

74.28 (8) home-delivered meals;

74.29 (9) nonmedical transportation;

74.30 (10) nursing services;

75.1 (11) chore services;

75.2 (12) companion services;

75.3 (13) nutrition services;

75.4 (14) family caregiver training and education;

75.5 (15) coaching and counseling;

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

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

75.12 (18) environmental accessibility and adaptations; and

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

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

75.21 <u>**EFFECTIVE DATE.**</u> <u>This section is effective January 1, 2024.</u>

75.22 Sec. 5. Minnesota Statutes 2022, section 256B.0917, subdivision 1b, is amended to read:

75.23 Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have the
75.24 meanings given.

75.25 (b) ~~"Community" means a town; township; city; or targeted neighborhood within a city;~~
75.26 ~~or a consortium of towns, townships, cities, or specific neighborhoods within a city.~~

75.27 ~~(c) "Core home and community-based services provider" means a Faith in Action, Living~~
75.28 ~~at Home Block Nurse, Congregational Nurse, or similar community-based program governed~~
75.29 ~~by a board, the majority of whose members reside within the program's service area, that~~
75.30 ~~organizes and uses volunteers and paid staff to deliver nonmedical services intended to~~

76.1 ~~assist older adults to identify and manage risks and to maintain their community living and~~
76.2 ~~integration in the community.~~

76.3 ~~(d)~~ "Eldercare development partnership" means a team of representatives of county
76.4 social service and public health agencies, the area agency on aging, local nursing home
76.5 providers, local home care providers, and other appropriate home and community-based
76.6 providers in the area agency's planning and service area.

76.7 ~~(e)~~ (c) "Long-term services and supports" means any service available under the elderly
76.8 waiver program or alternative care grant programs, nursing facility services, transportation
76.9 services, caregiver support and respite care services, and other home and community-based
76.10 services identified as necessary either to maintain lifestyle choices for older adults or to
76.11 support them to remain in their own home.

76.12 ~~(f)~~ (d) "Older adult" refers to an individual who is 65 years of age or older.

76.13 Sec. 6. Minnesota Statutes 2022, section 256B.0922, subdivision 1, is amended to read:

76.14 Subdivision 1. **Essential community supports.** (a) The purpose of the essential
76.15 community supports program is to provide targeted services to persons age 65 and older
76.16 who need essential community support, but whose needs do not meet the level of care
76.17 required for nursing facility placement under section 144.0724, subdivision 11.

76.18 (b) Essential community supports are available not to exceed ~~$400~~ $600 per person per
76.19 month. Essential community supports may be used as authorized within an authorization
76.20 period not to exceed 12 months. Services must be available to a person who:

76.21 (1) is age 65 or older;

76.22 (2) is not eligible for medical assistance;

76.23 (3) has received a community assessment under section 256B.0911, subdivisions 17 to
76.24 21, 23, 24, or 27, and does not require the level of care provided in a nursing facility;

76.25 (4) meets the financial eligibility criteria for the alternative care program under section
76.26 256B.0913, subdivision 4;

76.27 (5) has an assessment summary; and

76.28 (6) has been determined by a community assessment under section 256B.0911,
76.29 subdivisions 17 to 21, 23, 24, or 27, to be a person who would require provision of at least
76.30 one of the following services, as defined in the approved elderly waiver plan, in order to
76.31 maintain their community residence:

77.1 (i) adult day services;

77.2 (ii) caregiver support, including respite care;

77.3 (iii) homemaker support;

77.4 (iv) adult companion services;

77.5 ~~(iv)~~ (v) chores;

77.6 ~~(v)~~ (vi) a personal emergency response device or system;

77.7 ~~(vi)~~ (vii) home-delivered meals; or

77.8 ~~(vii)~~ (viii) community living assistance as defined by the commissioner.

77.9 (c) The person receiving any of the essential community supports in this subdivision
77.10 must also receive service coordination, not to exceed $600 in a 12-month authorization
77.11 period, as part of their assessment summary.

77.12 (d) A person who has been determined to be eligible for essential community supports
77.13 must be reassessed at least annually and continue to meet the criteria in paragraph (b) to
77.14 remain eligible for essential community supports.

77.15 (e) The commissioner is authorized to use federal matching funds for essential community
77.16 supports as necessary and to meet demand for essential community supports as outlined in
77.17 subdivision 2, and that amount of federal funds is appropriated to the commissioner for this
77.18 purpose.

77.19 Sec. 7. Minnesota Statutes 2022, section 256B.434, is amended by adding a subdivision
77.20 to read:

77.21 Subd. 4k. **Property rate increase for certain nursing facilities.** (a) A rate increase
77.22 under this subdivision ends upon the effective date of the transition of the facility's property
77.23 rate to a property payment rate under section 256R.26, subdivision 8.

77.24 (b) The commissioner shall increase the property rate of a nursing facility located at
77.25 1415 Almond Avenue, Saint Paul, in Ramsey County by $10.65 on September 1, 2023.

77.26 (c) The commissioner shall increase the property rate of a nursing facility located at
77.27 3111 Church Place, Duluth, in St. Louis County by $20.81 on September 1, 2023.

77.28 (d) The commissioner shall increase the property rate of a nursing facility located at
77.29 1102 Liberty Street SE, Chatfield, in Fillmore County by $21.35 on September 1, 2023.

77.30 **EFFECTIVE DATE.** This section is effective September 1, 2023.

78.1 Sec. 8. Minnesota Statutes 2022, section 256M.42, is amended to read:

78.2 **256M.42 ADULT PROTECTION GRANT ALLOCATIONS.**

78.3 Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated
78.4 under this section on an annual basis to each county board ~~and tribal government approved~~
78.5 ~~by the commissioner to assume county agency duties~~ for adult ~~protective services or as a~~
78.6 ~~lead investigative agency~~ protection under section 626.557 ~~on an annual basis in an amount~~
78.7 ~~determined~~ and to Tribal Nations that have voluntarily chosen by resolution of Tribal
78.8 government to participate in vulnerable adult protection programs according to the following
78.9 formula after the award of the amounts in paragraph (c):

78.10 (1) 25 percent must be allocated to the responsible agency on the basis of the number
78.11 of reports of suspected vulnerable adult maltreatment under sections 626.557 and 626.5572,
78.12 ~~when the county or tribe is responsible~~ as determined by the most recent data of the
78.13 commissioner; and

78.14 (2) 75 percent must be allocated to the responsible agency on the basis of the number
78.15 of screened-in reports for adult protective services or vulnerable adult maltreatment
78.16 investigations under sections 626.557 and 626.5572, ~~when the county or tribe is responsible~~
78.17 as determined by the most recent data of the commissioner.

78.18 (b) ~~The commissioner is precluded from changing the formula under this subdivision~~
78.19 ~~or recommending a change to the legislature without public review and input.~~
78.20 Notwithstanding this subdivision, no county must be awarded less than a minimum allocation
78.21 established by the commissioner.

78.22 (c) To receive money under this subdivision, a participating Tribal Nation must apply
78.23 to the commissioner. Of the amount appropriated for purposes of this section, the
78.24 commissioner must award $100,000 to each federally recognized Tribal Nation with a Tribal
78.25 resolution establishing a vulnerable adult protection program. Money received by a Tribal
78.26 Nation under this section must be used for its vulnerable adult protection program.

78.27 Subd. 2. **Payment.** The commissioner shall make allocations for the state fiscal year
78.28 starting July 1, ~~2019~~ 2023, and to each county board or tribal government on or before
78.29 October 10, ~~2019~~ 2023. The commissioner shall make allocations under subdivision 1 to
78.30 each county board or tribal government each year thereafter on or before July 10.

78.31 Subd. 3. ~~**Prohibition on supplanting existing money**~~ **Purpose of expenditures.** Money
78.32 received under this section must be used ~~for staffing for protection of vulnerable adults or~~
78.33 to meet the agency's duties under section 626.557 and to expand adult protective services

79.1 to stop, prevent, and reduce risks of maltreatment for adults accepted for services under
79.2 section . ~~Money must not be used to supplant current county or tribe expenditures for these~~
79.3 ~~purposes.~~

79.4 Subd. 4. **Required expenditures.** State funds must be used to expand, not supplant,
79.5 county or Tribal expenditures for the fiscal year 2023 base for adult protection programs,
79.6 service interventions, or multidisciplinary teams. This prohibition on county or Tribal
79.7 expenditures supplanting state money ends July 1, 2027.

79.8 Subd. 5. **County performance on adult protection measures.** The commissioner must
79.9 set vulnerable adult protection measures and standards for money received under this section.
79.10 The commissioner must require an underperforming county to demonstrate that the county
79.11 designated money allocated under this section for the purpose required and implemented a
79.12 reasonable strategy to improve adult protection performance, including the provision of a
79.13 performance improvement plan and additional remedies identified by the commissioner.
79.14 The commissioner may redirect up to 20 percent of a county's money under this section
79.15 toward the performance improvement plan.

79.16 Subd. 6. **American Indian adult protection.** Tribal Nations shall establish vulnerable
79.17 adult protection measures and standards and report annually to the commissioner on these
79.18 outcomes and the number of adults served.

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

79.20 Sec. 9. Minnesota Statutes 2022, section 256R.02, subdivision 19, is amended to read:

79.21 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing
79.22 home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;
79.23 family advisory council fee under section 144A.33; scholarships under section 256R.37;
79.24 planned closure rate adjustments under section 256R.40; consolidation rate adjustments
79.25 under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d;
79.26 single-bed room incentives under section 256R.41; property taxes, special assessments, and
79.27 payments in lieu of taxes; employer health insurance costs; quality improvement incentive
79.28 payment rate adjustments under section 256R.39; performance-based incentive payments
79.29 under section 256R.38; special dietary needs under section 256R.51; Public Employees
79.30 Retirement Association employer costs; and ~~border city~~ facility-specific rate ~~adjustments~~
79.31 modifications under section 256R.481.

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

80.1 Sec. 10. Minnesota Statutes 2022, section 256R.17, subdivision 2, is amended to read:

80.2 Subd. 2. **Case mix indices.** (a) The commissioner shall assign a case mix index to each
80.3 case mix classification ~~based on the Centers for Medicare and Medicaid Services staff time~~
80.4 ~~measurement study~~ <u>as determined by the commissioner of health under section 144.0724</u>.

80.5 (b) An index maximization approach shall be used to classify residents. "Index
80.6 maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

80.7 Sec. 11. Minnesota Statutes 2022, section 256R.25, is amended to read:

80.8 **256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.**

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

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

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

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

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

80.21 (f) The portion related to planned closure rate adjustments is as determined under section
80.22 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

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

80.25 (h) The portion related to single-bed room incentives is as determined under section
80.26 256R.41.

80.27 (i) The portions related to real estate taxes, special assessments, and payments made in
80.28 lieu of real estate taxes directly identified or allocated to the nursing facility are the allowable
80.29 amounts divided by the sum of the facility's resident days. Allowable costs under this
80.30 paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate
80.31 taxes shall not exceed the amount which the nursing facility would have paid to a city or

township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2022, section 256R.47, is amended to read:

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

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

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

82.1 (c) ~~The commissioner shall allow the benefits in clauses (1) to (5)~~ For nursing facilities
82.2 designated as critical access nursing facilities~~:~~, the commissioner shall allow a supplemental
82.3 payment above a facility's operating payment rate as determined to be necessary by the
82.4 commissioner to maintain access to nursing facilities services in isolated areas identified
82.5 in paragraph (b). The commissioner must approve the amounts of supplemental payments
82.6 through a memorandum of understanding. Supplemental payments to facilities under this
82.7 section must be in the form of time-limited rate adjustments included in the external fixed
82.8 payment rate under section 256R.25.

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

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

82.20 ~~(3) two designated critical access nursing facilities, with up to 100 beds in active service,~~
82.21 ~~may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part~~
82.22 ~~4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner~~
82.23 ~~of health shall consider each waiver request independently based on the criteria under~~
82.24 ~~Minnesota Rules, part 4658.0040;~~

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

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

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

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

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

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

83.5 Sec. 13. Minnesota Statutes 2022, section 256R.481, is amended to read:

83.6 **256R.481 FACILITY-SPECIFIC RATE ~~ADJUSTMENTS FOR BORDER CITY~~**
83.7 **~~FACILITIES~~ MODIFICATIONS.**

83.8 Subdivision 1. **Border city facilities.** (a) The commissioner shall allow each nonprofit
83.9 nursing facility located within the boundaries of the city of Breckenridge or Moorhead prior
83.10 to January 1, 2015, to apply once annually for a rate add-on to the facility's external fixed
83.11 costs payment rate.

83.12 (b) A facility seeking an add-on to its external fixed costs payment rate under this section
83.13 must apply annually to the commissioner to receive the add-on. A facility must submit the
83.14 application within 60 calendar days of the effective date of any add-on under this section.
83.15 The commissioner may waive the deadlines required by this paragraph under extraordinary
83.16 circumstances.

83.17 (c) The commissioner shall provide the add-on to each eligible facility that applies by
83.18 the application deadline.

83.19 (d) The add-on to the external fixed costs payment rate is the difference on January 1
83.20 of the median total payment rate for case mix classification PA1 of the nonprofit facilities
83.21 located in an adjacent city in another state and in cities contiguous to the adjacent city minus
83.22 the eligible nursing facility's total payment rate for case mix classification PA1 as determined
83.23 under section 256R.22, subdivision 4.

83.24 Subd. 2. **Nursing facility in Chisholm temporary rate add-on.** Effective July 1, 2023,
83.25 through December 31, 2027, the commissioner shall provide an external fixed rate add-on
83.26 for the nursing facility in Chisholm in the amount of $11.81. If this nursing facility completes
83.27 a moratorium exception project that is approved after March 27, 2023, this subdivision
83.28 expires the day before the effective date of that moratorium rate adjustment or December
83.29 31, 2027, whichever is earlier. The commissioner of human services shall notify the revisor
83.30 of statutes if this subdivision expires prior to December 31, 2027.

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

84.1 Sec. 14. Minnesota Statutes 2022, section 256R.53, is amended by adding a subdivision
84.2 to read:

84.3 Subd. 3. **Nursing facility in Fergus Falls.** Notwithstanding sections 256B.431, 256B.434,
84.4 and 256R.26, subdivision 9, a nursing facility located in Fergus Falls licensed for 105 beds
84.5 on September 1, 2021, must have the property portion of its total payment rate determined
84.6 according to sections 256R.26 to 256R.267.

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

84.8 Sec. 15. Minnesota Statutes 2022, section 256R.53, is amended by adding a subdivision
84.9 to read:

84.10 Subd. 4. **Nursing facility in Red Wing.** The operating payment rate for a facility located
84.11 in the city of Red Wing at 1412 West 4th Street is the sum of its direct care costs per
84.12 standardized day, its other care-related costs per resident day, and its other operating costs
84.13 per day.

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

84.15 Sec. 16. Minnesota Statutes 2022, section 256S.15, subdivision 2, is amended to read:

84.16 Subd. 2. **Foster care limit.** The elderly waiver payment for the foster care service in
84.17 combination with the payment for all other elderly waiver services, including case
84.18 management, must not exceed the monthly case mix budget cap for the participant as
84.19 specified in sections 256S.18, subdivision 3, and 256S.19, ~~subdivisions~~ subdivision 3 ~~and~~
84.20 ~~4~~.

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

84.22 Sec. 17. Minnesota Statutes 2022, section 256S.18, is amended by adding a subdivision
84.23 to read:

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

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

Sec. 18. Minnesota Statutes 2022, section 256S.19, subdivision 3, is amended to read:

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

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

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

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

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

Sec. 19. Minnesota Statutes 2022, section 256S.203, subdivision 1, is amended to read:

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

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

Sec. 20. Minnesota Statutes 2022, section 256S.203, subdivision 2, is amended to read:

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

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

Sec. 21. Minnesota Statutes 2022, section 256S.205, subdivision 3, is amended to read:

Subd. 3. **Rate adjustment eligibility criteria.** Only facilities satisfying all of the following conditions on September 1 of the application year are eligible for designation as a disproportionate share facility:

(1) at least ~~83.5~~ 80 percent of the residents of the facility are customized living residents; and

(2) at least ~~70~~ 50 percent of the customized living residents are elderly waiver participants.

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

Sec. 22. Minnesota Statutes 2022, section 256S.205, subdivision 5, is amended to read:

Subd. 5. **Rate adjustment; rate floor.** (a) Notwithstanding the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2, and the component service rates established under section 256S.201, subdivision 4, the commissioner must establish a rate floor equal to ~~$119~~ $139 per resident per day for 24-hour customized living services provided to an elderly waiver participant in a designated disproportionate share facility.

(b) The commissioner must apply the rate floor to the services described in paragraph (a) provided during the rate year.

(c) The commissioner must adjust the rate floor by the same amount and at the same time as any adjustment to the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2.

(d) The commissioner shall not implement the rate floor under this section if the customized living rates established under sections 256S.21 to 256S.215 will be implemented at 100 percent on January 1 of the year following an application year.

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

87.1 Sec. 23. **[256S.206] ASSISTED LIVING FACILITY CLOSURE PAYMENTS.**

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

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

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

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

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

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

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

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

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

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

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

88.4 Sec. 24. Minnesota Statutes 2022, section 256S.21, is amended to read:

88.5 **256S.21 RATE SETTING; APPLICATION; EVALUATION.**

88.6 Subdivision 1. **Application of rate setting.** The payment rate methodologies in sections
88.7 256S.2101 to 256S.215 apply to:

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

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

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

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

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

88.17 (1) the base wage index;

88.18 (2) the factors and supervision wage components; and

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

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

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

88.28 (1) worker wage costs;

88.29 (2) benefits paid;

88.30 (3) supervisor wage costs;

89.1 (4) executive wage costs;

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

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

89.4 (7) administrative costs paid;

89.5 (8) program costs paid;

89.6 (9) transportation costs paid;

89.7 (10) vacancy rates; and

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

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

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

89.21 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
89.22 consultation with stakeholders, may submit recommendations on rate methodologies in this
89.23 chapter, including ways to monitor and enforce the spending requirements directed in section
89.24 256S.2101, subdivision 3, through the reports directed by subdivision 2.

89.25 **EFFECTIVE DATE.** Subdivisions 1 and 2 are effective January 1, 2024. Subdivision
89.26 3 is effective January 1, 2025.

89.27 Sec. 25. Minnesota Statutes 2022, section 256S.2101, subdivision 2, is amended to read:

89.28 Subd. 2. **Phase-in for elderly waiver rates.** Except for home-delivered meals ~~as~~
89.29 ~~described in section 256S.215, subdivision 15~~ and the services in subdivision 2a, all rates
89.30 and rate components for elderly waiver, elderly waiver customized living, and elderly waiver

90.1 foster care under this chapter; alternative care under section 256B.0913; and essential
90.2 community supports under section 256B.0922 shall be:

90.3 (1) beginning January 1, 2024, the sum of ~~18.8~~ 27.8 percent of the rates calculated under
90.4 sections 256S.211 to 256S.215, and ~~81.2~~ 72.2 percent of the rates calculated using the rate
90.5 methodology in effect as of June 30, 2017~~. The rate for home-delivered meals shall be the~~
90.6 ~~sum of the service rate in effect as of January 1, 2019, and the increases described in section~~
90.7 ~~256S.215, subdivision 15~~; and

90.8 (2) beginning January 1, 2026, the sum of 25 percent of the rates calculated under sections
90.9 256S.211 to 256S.215, and 75 percent of the rates calculated using the rate methodology
90.10 in effect as of June 30, 2017.

90.11 Sec. 26. Minnesota Statutes 2022, section 256S.2101, is amended by adding a subdivision
90.12 to read:

90.13 Subd. 2a. **Service rates exempt from phase-in.** Subdivision 2 does not apply to rates
90.14 for homemaker services described in section 256S.215, subdivisions 9 to 11.

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

90.16 Sec. 27. Minnesota Statutes 2022, section 256S.2101, is amended by adding a subdivision
90.17 to read:

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

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

90.25 (1) wages and salaries;

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

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

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

91.4 (c) Compensation-related costs for persons employed in the central office of a corporation
91.5 or entity that has an ownership interest in the provider or exercises control over the provider,
91.6 or for persons paid by the provider under a management contract, do not count toward the
91.7 80 percent requirement under this subdivision.

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

91.20 Sec. 28. Minnesota Statutes 2022, section 256S.211, is amended by adding a subdivision
91.21 to read:

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2022, section 256S.211, is amended by adding a subdivision to read:

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

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

Sec. 30. Minnesota Statutes 2022, section 256S.212, is amended to read:

256S.212 RATE SETTING; BASE WAGE INDEX.

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

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

Subd. 3. **Home care aide base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home care aide base wage equals ~~50~~ 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code ~~31-1011~~ 31-1120); and ~~50~~ 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131).

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

93.1 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants
93.2 (SOC code ~~31-1014~~ 31-1131); and 33.34 percent of the Minneapolis-St. Paul-Bloomington,
93.3 MN-WI MetroSA average wage for home health and personal care aides (SOC code
93.4 31-1120).

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

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

93.16 Subd. 7. **Companion services base wage.** The companion services base wage equals
93.17 ~~50~~ 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage
93.18 for home health and personal ~~and home~~ care aides (SOC code ~~39-9021~~ 31-1120); and ~~50~~
93.19 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
93.20 maids and housekeeping cleaners (SOC code 37-2012).

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

93.28 Subd. 9. **Homemaker ~~services and~~ cleaning base wage.** The homemaker ~~services and~~
93.29 cleaning base wage equals ~~60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI~~
93.30 ~~MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent~~
93.31 ~~of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing~~
93.32 ~~assistants (SOC code 31-1014); and 20~~ 100 percent of the Minneapolis-St. Paul-Bloomington,
93.33 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).

95.1 Subd. 16. **Adult day services base wage.** The adult day services base wage equals 75
95.2 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home
95.3 health and personal care aides (SOC code 31-1120); and 25 percent of the Minneapolis-St.
95.4 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
95.5 31-1131).

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

95.7 Sec. 31. Minnesota Statutes 2022, section 256S.213, is amended to read:

95.8 **256S.213 RATE SETTING; FACTORS.**

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

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

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

95.20 (1) adult day services;

95.21 (2) customized living; and

95.22 (3) foster care.

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

95.26 (1) chore services;

95.27 (2) companion services;

95.28 (3) homemaker assistance with personal care;

95.29 (4) homemaker cleaning;

95.30 (5) homemaker home management;

96.1 (6) in-home respite care;

96.2 (7) individual community living support; and

96.3 (8) out-of-home respite care.

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

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

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

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

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

96.17 (1) chore services;

96.18 (2) companion services;

96.19 (3) homemaker assistance with personal care;

96.20 (4) homemaker cleaning;

96.21 (5) homemaker home management;

96.22 (6) in-home respite care;

96.23 (7) individual community support services; and

96.24 (8) out-of-home respite care.

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

96.26 (1) adult day services;

96.27 (2) chore services;

96.28 (3) companion services;

96.29 (4) homemaker assistance with personal care;

97.1 (5) homemaker cleaning;

97.2 (6) homemaker home management;

97.3 (7) in-home respite care;

97.4 (8) individual community living support; and

97.5 (9) out-of-home respite care.

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

97.7 Sec. 32. Minnesota Statutes 2022, section 256S.214, is amended to read:

97.8 **256S.214 RATE SETTING; ADJUSTED BASE WAGE.**

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

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

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

97.15 ~~(3)~~ (2) the position's base wage multiplied by the applicable program plan support factor
97.16 under section 256S.213, subdivision 3~~.~~; and

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

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

97.20 Sec. 33. Minnesota Statutes 2022, section 256S.215, subdivision 2, is amended to read:

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

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

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

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

98.1 Sec. 34. Minnesota Statutes 2022, section 256S.215, subdivision 3, is amended to read:

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

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

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

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

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

98.9 Sec. 35. Minnesota Statutes 2022, section 256S.215, subdivision 4, is amended to read:

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

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

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

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

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

98.17 Sec. 36. Minnesota Statutes 2022, section 256S.215, subdivision 7, is amended to read:

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

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

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

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

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

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

98.26 Sec. 37. Minnesota Statutes 2022, section 256S.215, subdivision 8, is amended to read:

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

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

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

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

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

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

99.7 Sec. 38. Minnesota Statutes 2022, section 256S.215, subdivision 9, is amended to read:

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

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

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

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

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

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

99.17 Sec. 39. Minnesota Statutes 2022, section 256S.215, subdivision 10, is amended to read:

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

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

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

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

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

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

99.26 Sec. 40. Minnesota Statutes 2022, section 256S.215, subdivision 11, is amended to read:

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

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

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

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

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

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

Sec. 41. Minnesota Statutes 2022, section 256S.215, subdivision 12, is amended to read:

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

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

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

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

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

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

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

Sec. 42. Minnesota Statutes 2022, section 256S.215, subdivision 13, is amended to read:

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

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

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

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

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

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

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

101.2 Sec. 43. Minnesota Statutes 2022, section 256S.215, subdivision 14, is amended to read:

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

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

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

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

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

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

101.12 Sec. 44. Minnesota Statutes 2022, section 256S.215, subdivision 15, is amended to read:

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

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

101.19 Sec. 45. Minnesota Statutes 2022, section 256S.215, subdivision 16, is amended to read:

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

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

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

101.29 (3) ~~$0.63 to cover the cost of meals.~~ multiply the result of clause (2) by the general and
101.30 administrative factor;

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

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

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

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

102.5 Sec. 46. Minnesota Statutes 2022, section 256S.215, subdivision 17, is amended to read:

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

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

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

102.14 (3) $0.63 to cover the cost of meals. multiply the result of clause (1) by the facility and
102.15 equipment factor;

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

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

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

102.19 Sec. 47. **DIRECTION TO COMMISSIONER; FUTURE PACE IMPLEMENTATION**
102.20 **FUNDING.**

102.21 The commissioner of human services must work with stakeholders to develop
102.22 recommendations for financing mechanisms to complete the actuarial work and cover the
102.23 administrative costs of a program of all-inclusive care for the elderly (PACE). The
102.24 commissioner must recommend a financing mechanism that could begin July 1, 2024. By
102.25 December 15, 2023, the commissioner shall inform the chairs and ranking minority members
102.26 of the legislative committees with jurisdiction over health care funding on the commissioner's
102.27 progress toward developing a recommended financing mechanism.

103.1 Sec. 48. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; CAREGIVER**
103.2 **RESPITE SERVICES GRANTS.**

103.3 Beginning in fiscal year 2025, the commissioner of human services must continue the
103.4 respite services for older adults grant program established under Laws 2021, First Special
103.5 Session chapter 7, article 17, section 17, subdivision 3, under the authority granted under
103.6 Minnesota Statutes, section 256.9756. The commissioner may begin the grant application
103.7 process for awarding grants under Minnesota Statutes, section 256.9756, during fiscal year
103.8 2024 in order to facilitate the continuity of the grant program during the transition from a
103.9 temporary program to a permanent one.

103.10 Sec. 49. **NURSING FACILITY FUNDING.**

103.11 (a) Effective July 1, 2023, through June 30, 2025, the total payment rate for all facilities
103.12 reimbursed under Minnesota Statutes, chapter 256R, must be increased by an amount per
103.13 resident day equal to a net state general fund expenditure of $37,045,000 in fiscal year 2024
103.14 and $37,045,000 in fiscal year 2025. Effective July 1, 2025, the total payment rate for all
103.15 facilities reimbursed under Minnesota Statutes, chapter 256R, must be increased by an
103.16 amount per resident day equal to a net state expenditure of $23,698,000 per fiscal year. The
103.17 rate increases under this paragraph are add-ons to the facilities' rates calculated under
103.18 Minnesota Statutes, chapter 256R.

103.19 (b) To be eligible to receive a payment under this section, a nursing facility must attest
103.20 to the commissioner of human services that the additional revenue will be used exclusively
103.21 to increase compensation-related costs for employees directly employed by the facility on
103.22 or after July 1, 2023, excluding:

103.23 (1) owners of the building and operation;

103.24 (2) persons employed in the central office of an entity that has any ownership interest
103.25 in the nursing facility or exercises control over the nursing facility;

103.26 (3) persons paid by the nursing facility under a management contract; and

103.27 (4) persons providing separately billable services.

103.28 (c) Contracted housekeeping, dietary, and laundry employees providing services on site
103.29 at the nursing facility are eligible for compensation-related cost increases under this section,
103.30 provided the agency that employs them submits to the nursing facility proof of the costs of
103.31 the increases provided to those employees.

103.32 (d) For purposes of this section, compensation-related costs include:

104.1 (1) permanent new increases to wages and salaries implemented on or after July 1, 2023,
104.2 and before September 1, 2023, for nursing facility employees;

104.3 (2) permanent new increases to wages and salaries implemented on or after July 1, 2023,
104.4 and before September 1, 2023, for employees in the organization's shared services
104.5 departments of hospital-attached nursing facilities for the nursing facility allocated share
104.6 of wages; and

104.7 (3) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment
104.8 taxes, PERA, workers' compensation, and pension and employee retirement accounts directly
104.9 associated with the wage and salary increases in clauses (1) and (2) incurred no later than
104.10 December 31, 2025, and paid for no later than June 30, 2026.

104.11 (e) A facility that receives a rate increase under this section must complete a distribution
104.12 plan in the form and manner determined by the commissioner. This plan must specify the
104.13 total amount of money the facility is estimated to receive from this rate increase and how
104.14 that money will be distributed to increase the allowable compensation-related costs described
104.15 in paragraph (d) for employees described in paragraphs (b) and (c). This estimate must be
104.16 computed by multiplying $28.65 by the sum of the medical assistance and private pay
104.17 resident days as defined in Minnesota Statutes, section 256R.02, subdivision 45, for the
104.18 period beginning October 1, 2021, through September 30, 2022, dividing this sum by 365
104.19 and multiplying the result by 915. A facility must submit its distribution plan to the
104.20 commissioner by October 1, 2023. The commissioner may review the distribution plan to
104.21 ensure that the payment rate adjustment per resident day is used in accordance with this
104.22 section. The commissioner may allow for a distribution plan amendment under exceptional
104.23 circumstances to be determined at the sole discretion of the commissioner.

104.24 (f) By September 1, 2023, a facility must post the distribution plan summary and leave
104.25 it posted for a period of at least six months in an area of the facility to which all employees
104.26 have access. The posted distribution plan summary must be in the form and manner
104.27 determined by the commissioner. The distribution plan summary must include instructions
104.28 regarding how to contact the commissioner, or the commissioner's representative, if an
104.29 employee believes the employee is covered by paragraph (b) or (c) and has not received the
104.30 compensation-related increases described in paragraph (d). The instruction to such employees
104.31 must include the e-mail address and telephone number that may be used by the employee
104.32 to contact the commissioner's representative. The posted distribution plan summary must
104.33 demonstrate how the increase in paragraph (a) received by the nursing facility from July 1,
104.34 2023, through December 1, 2025, will be used in full to pay the compensation-related costs
104.35 in paragraph (d) for employees described in paragraphs (b) and (c).

105.1 (g) If the nursing facility expends less on new compensation-related costs than the amount
105.2 that was made available by the rate increase in this section for that purpose, the amount of
105.3 this rate adjustment must be reduced to equal the amount utilized by the facility for purposes
105.4 authorized under this section. If the facility fails to post the distribution plan summary in
105.5 its facility as required, fails to submit its distribution plan to the commissioner by the due
105.6 date, or uses these funds for unauthorized purposes, these rate increases must be treated as
105.7 an overpayment and subsequently recovered.

105.8 (h) The commissioner shall not treat payments received under this section as an applicable
105.9 credit for purposes of setting total payment rates under Minnesota Statutes, chapter 256R.

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

105.13 Sec. 50. **INCREASED MEDICAL ASSISTANCE INCOME LIMIT FOR OLDER**
105.14 **ADULTS AND PERSONS WITH DISABILITIES.**

105.15 Effective July 1, 2023, the commissioner of human services must increase the income
105.16 limit under Minnesota Statutes, section 256B.056, subdivision 4, paragraph (a), to a level
105.17 that is projected to result in a net cost to the state of $5,000,000 for the 2026-2027 biennium.

105.18 Sec. 51. **REVISOR INSTRUCTION.**

105.19 The revisor of statutes shall change the headnote in Minnesota Statutes, section
105.20 256B.0917, from "HOME AND COMMUNITY-BASED SERVICES FOR OLDER
105.21 ADULTS" to "ELDERCARE DEVELOPMENT PARTNERSHIPS."

105.22 Sec. 52. **REPEALER.**

105.23 (a) Minnesota Statutes 2022, section 256B.0917, subdivisions 1a, 6, 7a, and 13, are
105.24 repealed.

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

105.26 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2023. Paragraph (b) is effective
105.27 January 1, 2024.

106.1 **ARTICLE 3**

106.2 **HEALTH CARE**

106.3 Section 1. Minnesota Statutes 2022, section 252.27, subdivision 2a, is amended to read:

106.4 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
106.5 not including a child determined eligible for medical assistance without consideration of
106.6 parental income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or a
106.7 child accessing home and community-based waiver services, must contribute to the cost of
106.8 services used by making monthly payments on a sliding scale based on income, unless the
106.9 child is married or has been married, parental rights have been terminated, or the child's
106.10 adoption is subsidized according to chapter 259A or through title IV-E of the Social Security
106.11 Act. The parental contribution is a partial or full payment for medical services provided for
106.12 diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal
106.13 care services as defined in United States Code, title 26, section 213, needed by the child
106.14 with a chronic illness or disability.

106.15 (b) For households with adjusted gross income equal to or greater than 275 percent of
106.16 federal poverty guidelines, the parental contribution shall be computed by applying the
106.17 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

106.18 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
106.19 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
106.20 contribution shall be determined using a sliding fee scale established by the commissioner
106.21 of human services which begins at 1.65 percent of adjusted gross income at 275 percent of
106.22 federal poverty guidelines and increases to 4.5 percent of adjusted gross income for those
106.23 with adjusted gross income up to 545 percent of federal poverty guidelines;

106.24 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
106.25 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
106.26 4.5 percent of adjusted gross income;

106.27 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
106.28 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
106.29 shall be determined using a sliding fee scale established by the commissioner of human
106.30 services which begins at 4.5 percent of adjusted gross income at 675 percent of federal
106.31 poverty guidelines and increases to 5.99 percent of adjusted gross income for those with
106.32 adjusted gross income up to 975 percent of federal poverty guidelines; and

106.33 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
106.34 guidelines, the parental contribution shall be 7.49 percent of adjusted gross income.

107.1 If the child lives with the parent, the annual adjusted gross income is reduced by $2,400
107.2 prior to calculating the parental contribution. If the child resides in an institution specified
107.3 in section 256B.35, the parent is responsible for the personal needs allowance specified
107.4 under that section in addition to the parental contribution determined under this section.
107.5 The parental contribution is reduced by any amount required to be paid directly to the child
107.6 pursuant to a court order, but only if actually paid.

107.7 (c) The household size to be used in determining the amount of contribution under
107.8 paragraph (b) includes natural and adoptive parents and their dependents, including the
107.9 child receiving services. Adjustments in the contribution amount due to annual changes in
107.10 the federal poverty guidelines shall be implemented on the first day of July following
107.11 publication of the changes.

107.12 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
107.13 natural or adoptive parents determined according to the previous year's federal tax form,
107.14 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
107.15 have been used to purchase a home shall not be counted as income.

107.16 (e) The contribution shall be explained in writing to the parents at the time eligibility
107.17 for services is being determined. The contribution shall be made on a monthly basis effective
107.18 with the first month in which the child receives services. Annually upon redetermination
107.19 or at termination of eligibility, if the contribution exceeded the cost of services provided,
107.20 the local agency or the state shall reimburse that excess amount to the parents, either by
107.21 direct reimbursement if the parent is no longer required to pay a contribution, or by a
107.22 reduction in or waiver of parental fees until the excess amount is exhausted. All
107.23 reimbursements must include a notice that the amount reimbursed may be taxable income
107.24 if the parent paid for the parent's fees through an employer's health care flexible spending
107.25 account under the Internal Revenue Code, section 125, and that the parent is responsible
107.26 for paying the taxes owed on the amount reimbursed.

107.27 (f) The monthly contribution amount must be reviewed at least every 12 months; when
107.28 there is a change in household size; and when there is a loss of or gain in income from one
107.29 month to another in excess of ten percent. The local agency shall mail a written notice 30
107.30 days in advance of the effective date of a change in the contribution amount. A decrease in
107.31 the contribution amount is effective in the month that the parent verifies a reduction in
107.32 income or change in household size.

107.33 (g) Parents of a minor child who do not live with each other shall each pay the
107.34 contribution required under paragraph (a). An amount equal to the annual court-ordered

108.1 child support payment actually paid on behalf of the child receiving services shall be deducted
108.2 from the adjusted gross income of the parent making the payment prior to calculating the
108.3 parental contribution under paragraph (b).

108.4 (h) The contribution under paragraph (b) shall be increased by an additional five percent
108.5 if the local agency determines that insurance coverage is available but not obtained for the
108.6 child. For purposes of this section, "available" means the insurance is a benefit of employment
108.7 for a family member at an annual cost of no more than five percent of the family's annual
108.8 income. For purposes of this section, "insurance" means health and accident insurance
108.9 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
108.10 self-insured plan, or preferred provider organization.

108.11 Parents who have more than one child receiving services shall not be required to pay
108.12 more than the amount for the child with the highest expenditures. There shall be no resource
108.13 contribution from the parents. The parent shall not be required to pay a contribution in
108.14 excess of the cost of the services provided to the child, not counting payments made to
108.15 school districts for education-related services. Notice of an increase in fee payment must
108.16 be given at least 30 days before the increased fee is due.

108.17 (i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in
108.18 the 12 months prior to July 1:

108.19 (1) the parent applied for insurance for the child;

108.20 (2) the insurer denied insurance;

108.21 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
108.22 complaint or appeal, in writing, to the commissioner of health or the commissioner of
108.23 commerce, or litigated the complaint or appeal; and

108.24 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

108.25 For purposes of this section, "insurance" has the meaning given in paragraph (h).

108.26 A parent who has requested a reduction in the contribution amount under this paragraph
108.27 shall submit proof in the form and manner prescribed by the commissioner or county agency,
108.28 including~~,~~ but not limited to~~,~~ the insurer's denial of insurance, the written letter or complaint
108.29 of the parents, court documents, and the written response of the insurer approving insurance.
108.30 The determinations of the commissioner or county agency under this paragraph are not rules
108.31 subject to chapter 14.

109.1 Sec. 2. Minnesota Statutes 2022, section 256B.04, is amended by adding a subdivision to
109.2 read:

109.3 Subd. 26. **Notice of employed persons with disabilities program.** At the time of initial
109.4 enrollment and at least annually thereafter, the commissioner shall provide information on
109.5 the medical assistance program for employed persons with disabilities under section
109.6 256B.057, subdivision 9, to all medical assistance enrollees who indicate they have a
109.7 disability.

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

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

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

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

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

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

109.30 (5) for a person who no longer qualifies as an employed person with a disability due to
109.31 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
109.32 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility

as an employed person with a disability~~, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d)~~;

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

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

(b) No asset limit shall apply to persons eligible under ~~section~~ sections 256B.055, subdivision 15, and 256B.057, subdivision 9.

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

Sec. 4. Minnesota Statutes 2022, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

~~(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:~~

~~(1) all assets excluded under section 256B.056;~~

~~(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;~~

~~(3) medical expense accounts set up through the person's employer; and~~

~~(4) spousal assets, including spouse's share of jointly held assets.~~

~~(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).~~

~~(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income~~

~~at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.~~

~~(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.~~

~~(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).~~

~~(4)~~ (d) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

~~(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.~~

~~(f)~~ (e) A person's eligibility ~~and premium~~ shall be determined by the local county agency. ~~Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.~~

~~(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported.~~ (f) Enrollees must report any change in income or household size within ten days of when the change occurs. ~~A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.~~

~~(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.~~

~~(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled.~~

113.1 ~~Nonpayment shall include payment with a returned, refused, or dishonored instrument. The~~
113.2 ~~commissioner may require a guaranteed form of payment as the only means to replace a~~
113.3 ~~returned, refused, or dishonored instrument.~~

113.4 ~~(j)~~ (g) The commissioner is authorized to determine that a premium amount was calculated
113.5 or billed in error, make corrections to financial records and billing systems, and refund
113.6 premiums collected in error.

113.7 (h) For enrollees ~~whose income does not exceed 200 percent of the federal poverty~~
113.8 ~~guidelines~~ who are: (1) eligible under this subdivision and ~~who are~~ also enrolled in Medicare~~,~~;
113.9 and (2) not eligible for medical assistance reimbursement of Medicare premiums under
113.10 subdivisions 3, 3a, 3b, or 4, the commissioner shall reimburse the enrollee for Medicare
113.11 part A and Medicare part B premiums ~~under section 256B.0625, subdivision 15, paragraph~~
113.12 ~~(a).~~ and part A and part B coinsurance and deductibles. Reimbursement of the Medicare
113.13 coinsurance and deductibles, when added to the amount paid by Medicare, must not exceed
113.14 the total rate the provider would have received for the same service or services if the person
113.15 was receiving benefits as a qualified Medicare beneficiary.

113.16 (i) The commissioner must permit any individual who was disenrolled for nonpayment
113.17 of premiums previously required under this subdivision to reapply for medical assistance
113.18 under this subdivision and be reenrolled if eligible without paying past due premiums.

113.19 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,
113.20 whichever occurs later. The commissioner of human services shall notify the revisor of
113.21 statutes when federal approval is obtained.

113.22 Sec. 5. Minnesota Statutes 2022, section 256B.0625, subdivision 17, is amended to read:

113.23 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
113.24 means motor vehicle transportation provided by a public or private person that serves
113.25 Minnesota health care program beneficiaries who do not require emergency ambulance
113.26 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

113.27 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
113.28 emergency medical care or transportation costs incurred by eligible persons in obtaining
113.29 emergency or nonemergency medical care when paid directly to an ambulance company,
113.30 nonemergency medical transportation company, or other recognized providers of
113.31 transportation services. Medical transportation must be provided by:

113.32 (1) nonemergency medical transportation providers who meet the requirements of this
113.33 subdivision;

114.1 (2) ambulances, as defined in section 144E.001, subdivision 2;

114.2 (3) taxicabs that meet the requirements of this subdivision;

114.3 (4) public transit, as defined in section 174.22, subdivision 7; or

114.4 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
114.5 subdivision 1, paragraph (h).

114.6 (c) Medical assistance covers nonemergency medical transportation provided by
114.7 nonemergency medical transportation providers enrolled in the Minnesota health care
114.8 programs. All nonemergency medical transportation providers must comply with the
114.9 operating standards for special transportation service as defined in sections 174.29 to 174.30
114.10 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
114.11 commissioner and reported on the claim as the individual who provided the service. All
114.12 nonemergency medical transportation providers shall bill for nonemergency medical
114.13 transportation services in accordance with Minnesota health care programs criteria. Publicly
114.14 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
114.15 requirements outlined in this paragraph.

114.16 (d) An organization may be terminated, denied, or suspended from enrollment if:

114.17 (1) the provider has not initiated background studies on the individuals specified in
114.18 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

114.19 (2) the provider has initiated background studies on the individuals specified in section
114.20 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

114.21 (i) the commissioner has sent the provider a notice that the individual has been
114.22 disqualified under section 245C.14; and

114.23 (ii) the individual has not received a disqualification set-aside specific to the special
114.24 transportation services provider under sections 245C.22 and 245C.23.

114.25 (e) The administrative agency of nonemergency medical transportation must:

114.26 (1) adhere to the policies defined by the commissioner;

114.27 (2) pay nonemergency medical transportation providers for services provided to
114.28 Minnesota health care programs beneficiaries to obtain covered medical services;

114.29 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
114.30 trips, and number of trips by mode; and

115.1 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
115.2 administrative structure assessment tool that meets the technical requirements established
115.3 by the commissioner, reconciles trip information with claims being submitted by providers,
115.4 and ensures prompt payment for nonemergency medical transportation services.

115.5 (f) Until the commissioner implements the single administrative structure and delivery
115.6 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
115.7 commissioner or an entity approved by the commissioner that does not dispatch rides for
115.8 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

115.9 (g) The commissioner may use an order by the recipient's attending physician, advanced
115.10 practice registered nurse, physician assistant, or a medical or mental health professional to
115.11 certify that the recipient requires nonemergency medical transportation services.
115.12 Nonemergency medical transportation providers shall perform driver-assisted services for
115.13 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
115.14 at and return to the individual's residence or place of business, assistance with admittance
115.15 of the individual to the medical facility, and assistance in passenger securement or in securing
115.16 of wheelchairs, child seats, or stretchers in the vehicle.

115.17 Nonemergency medical transportation providers must take clients to the health care
115.18 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
115.19 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
115.20 authorization from the local agency.

115.21 Nonemergency medical transportation providers may not bill for separate base rates for
115.22 the continuation of a trip beyond the original destination. Nonemergency medical
115.23 transportation providers must maintain trip logs, which include pickup and drop-off times,
115.24 signed by the medical provider or client, whichever is deemed most appropriate, attesting
115.25 to mileage traveled to obtain covered medical services. Clients requesting client mileage
115.26 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
115.27 services.

115.28 (h) The administrative agency shall use the level of service process established by the
115.29 commissioner to determine the client's most appropriate mode of transportation. If public
115.30 transit or a certified transportation provider is not available to provide the appropriate service
115.31 mode for the client, the client may receive a onetime service upgrade.

115.32 (i) The covered modes of transportation are:

116.1 (1) client reimbursement, which includes client mileage reimbursement provided to
116.2 clients who have their own transportation, or to family or an acquaintance who provides
116.3 transportation to the client;

116.4 (2) volunteer transport, which includes transportation by volunteers using their own
116.5 vehicle;

116.6 (3) unassisted transport, which includes transportation provided to a client by a taxicab
116.7 or public transit. If a taxicab or public transit is not available, the client can receive
116.8 transportation from another nonemergency medical transportation provider;

116.9 (4) assisted transport, which includes transport provided to clients who require assistance
116.10 by a nonemergency medical transportation provider;

116.11 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
116.12 dependent on a device and requires a nonemergency medical transportation provider with
116.13 a vehicle containing a lift or ramp;

116.14 (6) protected transport, which includes transport provided to a client who has received
116.15 a prescreening that has deemed other forms of transportation inappropriate and who requires
116.16 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
116.17 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
116.18 the vehicle driver; and (ii) who is certified as a protected transport provider; and

116.19 (7) stretcher transport, which includes transport for a client in a prone or supine position
116.20 and requires a nonemergency medical transportation provider with a vehicle that can transport
116.21 a client in a prone or supine position.

116.22 (j) The local agency shall be the single administrative agency and shall administer and
116.23 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
116.24 commissioner has developed, made available, and funded the web-based single administrative
116.25 structure, assessment tool, and level of need assessment under subdivision 18e. The local
116.26 agency's financial obligation is limited to funds provided by the state or federal government.

116.27 (k) The commissioner shall:

116.28 (1) verify that the mode and use of nonemergency medical transportation is appropriate;

116.29 (2) verify that the client is going to an approved medical appointment; and

116.30 (3) investigate all complaints and appeals.

116.31 (l) The administrative agency shall pay for the services provided in this subdivision and
116.32 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,

local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and ~~$11~~ $12.93 for the base rate and ~~$1.30~~ $1.53 per mile when provided by a nonemergency medical transportation provider;

(4) ~~$13~~ $15.28 for the base rate and ~~$1.30~~ $1.53 per mile for assisted transport;

(5) ~~$18~~ $21.15 for the base rate and ~~$1.55~~ $1.82 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

118.1 (q) The commissioner, when determining reimbursement rates for nonemergency medical
118.2 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
118.3 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

118.4 (r) Effective for the first day of each calendar quarter in which the price of gasoline as
118.5 posted publicly by the United States Energy Information Administration exceeds $3.00 per
118.6 gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent
118.7 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
118.8 or decrease must be calculated using a base gasoline price of $3.00. The percentage increase
118.9 or decrease must be calculated using the average of the most recently available price of all
118.10 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
118.11 Administration.

118.12 **EFFECTIVE DATE.** This section is effective July 1, 2023, or upon federal approval,
118.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
118.14 when federal approval is obtained.

118.15 Sec. 6. Minnesota Statutes 2022, section 256B.0625, subdivision 17a, is amended to read:

118.16 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance
118.17 services. Providers shall bill ambulance services according to Medicare criteria.
118.18 Nonemergency ambulance services shall not be paid as emergencies. Effective for services
118.19 rendered on or after July 1, 2001, medical assistance payments for ambulance services shall
118.20 be paid at the Medicare reimbursement rate or at the medical assistance payment rate in
118.21 effect on July 1, 2000, whichever is greater.

118.22 (b) Effective for services provided on or after July 1, 2016, medical assistance payment
118.23 rates for ambulance services identified in this paragraph are increased by five percent.
118.24 Capitation payments made to managed care plans and county-based purchasing plans for
118.25 ambulance services provided on or after January 1, 2017, shall be increased to reflect this
118.26 rate increase. The increased rate described in this paragraph applies to ambulance service
118.27 providers whose base of operations as defined in section 144E.10 is located:

118.28 (1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
118.29 the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

118.30 (2) within a municipality with a population of less than 1,000.

118.31 (c) Effective for the first day of each calendar quarter in which the price of gasoline as
118.32 posted publicly by the United States Energy Information Administration exceeds $3.00 per
118.33 gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one

119.1 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
119.2 increase or decrease must be calculated using a base gasoline price of $3.00. The percentage
119.3 increase or decrease must be calculated using the average of the most recently available
119.4 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
119.5 Information Administration.

119.6 **EFFECTIVE DATE.** This section is effective July 1, 2023, or upon federal approval,
119.7 whichever is later. The commissioner of human services shall notify the revisor of statutes
119.8 when federal approval is obtained.

119.9 Sec. 7. Minnesota Statutes 2022, section 256B.0625, subdivision 22, is amended to read:

119.10 Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public
119.11 Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21
119.12 or under who elects to receive hospice services does not waive coverage for services that
119.13 are related to the treatment of the condition for which a diagnosis of terminal illness has
119.14 been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care
119.15 services under this subdivision.

119.16 Sec. 8. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
119.17 to read:

119.18 Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for**
119.19 **children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is
119.20 for recipients age 21 or under who elect to receive hospice care delivered in a facility that
119.21 is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility
119.22 under section 144A.75, subdivision 13, paragraph (a). Hospice care services under
119.23 subdivision 22 are not hospice respite or end-of-life care under this subdivision.

119.24 (b) The payment rates for coverage under this subdivision must be 100 percent of the
119.25 Medicare rate for continuous home care hospice services as published in the Centers for
119.26 Medicare and Medicaid Services annual final rule updating payments and policies for hospice
119.27 care.Payment for hospice respite and end-of-life care under this subdivision must be made
119.28 from state funds, though the commissioner must seek to obtain federal financial participation
119.29 for the payments. Payment for hospice respite and end-of-life care must be paid to the
119.30 residential hospice facility and are not included in any limit or cap amount applicable to
119.31 hospice services payments to the elected hospice services provider.

120.1 (c) Certification of the residential hospice facility by the federal Medicare program must
120.2 not be a requirement of medical assistance payment for hospice respite and end-of-life care
120.3 under this subdivision.

120.4 Sec. 9. Minnesota Statutes 2022, section 256B.14, subdivision 2, is amended to read:

120.5 Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to
120.6 determine the ability of responsible relatives to contribute partial or complete payment or
120.7 repayment of medical assistance furnished to recipients for whom they are responsible. All
120.8 medical assistance exclusions shall be allowed, and a resource limit of $10,000 for
120.9 nonexcluded resources shall be implemented. Above these limits, a contribution of one-third
120.10 of the excess resources shall be required. These rules shall not require payment or repayment
120.11 when payment would cause undue hardship to the responsible relative or that relative's
120.12 immediate family. These rules ~~shall be consistent with the requirements of section 252.27~~
120.13 ~~for~~ do not apply to parents of children whose eligibility for medical assistance was determined
120.14 without deeming of the parents' resources and income under the Tax Equity and Fiscal
120.15 Responsibility Act (TEFRA) option or to parents of children accessing home and
120.16 community-based waiver services. The county agency shall give the responsible relative
120.17 notice of the amount of the payment or repayment. If the state agency or county agency
120.18 finds that notice of the payment obligation was given to the responsible relative, but that
120.19 the relative failed or refused to pay, a cause of action exists against the responsible relative
120.20 for that portion of medical assistance granted after notice was given to the responsible
120.21 relative, which the relative was determined to be able to pay.

120.22 The action may be brought by the state agency or the county agency in the county where
120.23 assistance was granted, for the assistance, together with the costs of disbursements incurred
120.24 due to the action.

120.25 In addition to granting the county or state agency a money judgment, the court may,
120.26 upon a motion or order to show cause, order continuing contributions by a responsible
120.27 relative found able to repay the county or state agency. The order shall be effective only
120.28 for the period of time during which the recipient receives medical assistance from the county
120.29 or state agency.

120.30 Sec. 10. Minnesota Statutes 2022, section 256B.766, is amended to read:

120.31 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

120.32 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
120.33 services, shall be reduced by three percent, except that for the period July 1, 2009, through

121.1 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
121.2 and general assistance medical care programs, prior to third-party liability and spenddown
121.3 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
121.4 occupational therapy services, and speech-language pathology and related services as basic
121.5 care services. The reduction in this paragraph shall apply to physical therapy services,
121.6 occupational therapy services, and speech-language pathology and related services provided
121.7 on or after July 1, 2010.

121.8 (b) Payments made to managed care plans and county-based purchasing plans shall be
121.9 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
121.10 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
121.11 to reflect the reduction effective July 1, 2010.

121.12 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
121.13 total payments for outpatient hospital facility fees shall be reduced by five percent from the
121.14 rates in effect on August 31, 2011.

121.15 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
121.16 total payments for ambulatory surgery centers facility fees, medical supplies and durable
121.17 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
121.18 renal dialysis services, laboratory services, public health nursing services, physical therapy
121.19 services, occupational therapy services, speech therapy services, eyeglasses not subject to
121.20 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
121.21 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
121.22 2011.

121.23 (e) Effective for services provided on or after September 1, 2014, payments for
121.24 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
121.25 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
121.26 and hearing aids not subject to a volume purchase contract shall be increased by three percent
121.27 and payments for outpatient hospital facility fees shall be increased by three percent.
121.28 Payments made to managed care plans and county-based purchasing plans shall not be
121.29 adjusted to reflect payments under this paragraph.

121.30 (f) Payments for medical supplies and durable medical equipment not subject to a volume
121.31 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
121.32 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
121.33 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,

122.1 provided on or after July 1, 2015, shall be increased by three percent from the rates as
122.2 determined under paragraphs (i) and (j).

122.3 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
122.4 hospital facility fees, medical supplies and durable medical equipment not subject to a
122.5 volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified
122.6 in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent
122.7 from the rates in effect on June 30, 2015. Payments made to managed care plans and
122.8 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

122.9 (h) This section does not apply to physician and professional services, inpatient hospital
122.10 services, family planning services, mental health services, dental services, prescription
122.11 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
122.12 health services, and Medicare cost-sharing.

122.13 (i) Effective for services provided on or after July 1, 2015, the following categories of
122.14 medical supplies and durable medical equipment shall be individually priced items: ~~enteral~~
122.15 ~~nutrition and supplies,~~ customized and other specialized tracheostomy tubes and supplies,
122.16 electric patient lifts, and durable medical equipment repair and service. This paragraph does
122.17 not apply to medical supplies and durable medical equipment subject to a volume purchase
122.18 contract, products subject to the preferred diabetic testing supply program, and items provided
122.19 to dually eligible recipients when Medicare is the primary payer for the item. The
122.20 commissioner shall not apply any medical assistance rate reductions to durable medical
122.21 equipment as a result of Medicare competitive bidding.

122.22 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
122.23 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
122.24 as follows:

122.25 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
122.26 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
122.27 increased by 9.5 percent; and

122.28 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
122.29 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
122.30 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
122.31 being applied after calculation of any increased payment rate under clause (1).

122.32 This paragraph does not apply to medical supplies and durable medical equipment subject
122.33 to a volume purchase contract, products subject to the preferred diabetic testing supply
122.34 program, items provided to dually eligible recipients when Medicare is the primary payer

123.1 for the item, and individually priced items identified in paragraph (i). Payments made to
123.2 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
123.3 rate increases in this paragraph.

123.4 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,
123.5 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
123.6 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
123.7 lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For
123.8 payments made in accordance with this paragraph, if, and to the extent that, the commissioner
123.9 identifies that the state has received federal financial participation for ventilators in excess
123.10 of the amount allowed effective January 1, 2018, under United States Code, title 42, section
123.11 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and
123.12 Medicaid Services with state funds and maintain the full payment rate under this paragraph.

123.13 (l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that
123.14 are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social
123.15 Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall
123.16 not be applied to the items listed in this paragraph.

123.17 (m) For dates of service on or after July 1, 2023, through June 30, 2024, enteral nutrition
123.18 and supplies must be paid according to this paragraph. If sufficient data exists for a product
123.19 or supply, payment must be based upon the 50th percentile of the usual and customary
123.20 charges per product code submitted to the department, using only charges submitted per
123.21 unit. Increases in rates resulting from the 50th percentile payment method must not exceed
123.22 150 percent of the previous fiscal year's rate per code and product combination. Data are
123.23 sufficient if: (1) the department has at least 100 paid claim lines by at least ten different
123.24 providers for a given product or supply; or (2) in the absence of the data in clause (1), the
123.25 department has at least 20 claim lines by at least five different providers for a product or
123.26 supply that does not meet the requirements of clause (1). If sufficient data are not available
123.27 to calculate the 50th percentile for enteral products or supplies, the payment rate shall be
123.28 the payment rate in effect on June 30, 2023.

123.29 (n) For dates of service on or after July 1, 2024, enteral nutrition and supplies must be
123.30 paid according to this paragraph and updated annually each January 1. If sufficient data
123.31 exists for a product or supply, payment must be based upon the 50th percentile of the usual
123.32 and customary charges per product code submitted to the department for the previous
123.33 calendar year, using only charges submitted per unit. Increases in rates resulting from the
123.34 50th percentile payment method must not exceed 150 percent of the previous year's rate per
123.35 code and product combination. Data are sufficient if: (1) the department has at least 100

124.1 paid claim lines by at least ten different providers for a given product or supply; or (2) in
124.2 the absence of the data in clause (1), the department has at least 20 claim lines by at least
124.3 five different providers for a product or supply that does not meet the requirements of clause
124.4 (1). If sufficient data is not available to calculate the 50th percentile for enteral products or
124.5 supplies, the payment shall be the manufacturer's suggested retail price of that product or
124.6 supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment
124.7 shall be the actual acquisition cost of that product or supply plus 20 percent.

124.8 **ARTICLE 4**

124.9 **BEHAVIORAL HEALTH**

124.10 Section 1. Minnesota Statutes 2022, section 4.046, subdivision 6, is amended to read:

124.11 Subd. 6. **Office of addiction and recovery; director.** An Office of Addiction and
124.12 Recovery is created in the Department of Management and Budget. The governor must
124.13 appoint an addiction and recovery director, who shall serve as chair of the subcabinet and
124.14 administer the Office of Addiction and Recovery. The director shall serve in the unclassified
124.15 service and shall report to the governor. The director must:

124.16 (1) make efforts to break down silos and work across agencies to better target the state's
124.17 role in addressing addiction, treatment, and recovery;

124.18 (2) assist in leading the subcabinet and the advisory council toward progress on
124.19 measurable goals that track the state's efforts in combatting addiction; and

124.20 (3) establish and manage external partnerships and build relationships with communities,
124.21 community leaders, and those who have direct experience with addiction to ensure that all
124.22 voices of recovery are represented in the work of the subcabinet and advisory council.

124.23 Sec. 2. Minnesota Statutes 2022, section 4.046, subdivision 7, is amended to read:

124.24 Subd. 7. **Staff and administrative support.** The commissioner of ~~human services~~
124.25 management and budget, in coordination with other state agencies and boards as applicable,
124.26 must provide staffing and administrative support to the addiction and recovery director, the
124.27 subcabinet, and the advisory council and the Office of Addiction and Recovery established
124.28 in this section.

125.1 Sec. 3. Minnesota Statutes 2022, section 4.046, is amended by adding a subdivision to
125.2 read:

125.3 Subd. 8. **Division of Youth Substance Use and Addiction Recovery.** (a) A Division
125.4 of Youth Substance Use and Addiction Recovery is created in the Office of Addiction and
125.5 Recovery to focus on preventing adolescent substance use and addiction. The addiction and
125.6 recovery director shall employ a director to lead the Division of Youth Substance Use and
125.7 Addiction Recovery and staff necessary to fulfill its purpose.

125.8 (b) The director of the division shall:

125.9 (1) make efforts to bridge mental health and substance abuse treatment silos and work
125.10 across agencies to focus the state's role and resources in preventing youth substance use
125.11 and addiction;

125.12 (2) develop and share resources on evidence-based strategies and programs for addressing
125.13 youth substance use and prevention;

125.14 (3) establish and manage external partnerships and build relationships with communities,
125.15 community leaders, and persons and organizations with direct experience with youth
125.16 substance use and addiction; and

125.17 (4) work to achieve progress on established measurable goals that track the state's efforts
125.18 in preventing substance use and addiction among the state's youth population.

125.19 Sec. 4. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to
125.20 read:

125.21 Subd. 4a. **American Society of Addiction Medicine criteria or ASAM**
125.22 **criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" has the
125.23 meaning provided in section 254B.01, subdivision 2a.

125.24 Sec. 5. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to
125.25 read:

125.26 Subd. 20c. **Protective factors.** "Protective factors" means the actions or efforts a person
125.27 can take to reduce the negative impact of certain issues, such as substance use disorders,
125.28 mental health disorders, and risk of suicide. Protective factors include connecting to positive
125.29 supports in the community, a good diet, exercise, attending counseling or 12-step groups,
125.30 and taking medications.

Sec. 6. Minnesota Statutes 2022, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 1a, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7); and 245G.17.

Sec. 7. Minnesota Statutes 2022, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** ~~(a)~~ A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within ~~three~~ five calendar days from the day of service initiation for a residential program or ~~within three calendar days on which a treatment session has been provided of the day of service initiation for a client~~ by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:~~

127.1 ~~(1) age, sex, cultural background, sexual orientation, living situation, economic status,~~
127.2 ~~and level of education;~~

127.3 ~~(2) a description of the circumstances on the day of service initiation;~~

127.4 ~~(3) a list of previous attempts at treatment for substance misuse or substance use disorder,~~
127.5 ~~compulsive gambling, or mental illness;~~

127.6 ~~(4) a list of substance use history including amounts and types of substances used,~~
127.7 ~~frequency and duration of use, periods of abstinence, and circumstances of relapse, if any.~~
127.8 ~~For each substance used within the previous 30 days, the information must include the date~~
127.9 ~~of the most recent use and address the absence or presence of previous withdrawal symptoms;~~

127.10 ~~(5) specific problem behaviors exhibited by the client when under the influence of~~
127.11 ~~substances;~~

127.12 ~~(6) the client's desire for family involvement in the treatment program, family history~~
127.13 ~~of substance use and misuse, history or presence of physical or sexual abuse, and level of~~
127.14 ~~family support;~~

127.15 ~~(7) physical and medical concerns or diagnoses, current medical treatment needed or~~
127.16 ~~being received related to the diagnoses, and whether the concerns need to be referred to an~~
127.17 ~~appropriate health care professional;~~

127.18 ~~(8) mental health history, including symptoms and the effect on the client's ability to~~
127.19 ~~function; current mental health treatment; and psychotropic medication needed to maintain~~
127.20 ~~stability. The assessment must utilize screening tools approved by the commissioner pursuant~~
127.21 ~~to section 245.4863 to identify whether the client screens positive for co-occurring disorders;~~

127.22 ~~(9) arrests and legal interventions related to substance use;~~

127.23 ~~(10) a description of how the client's use affected the client's ability to function~~
127.24 ~~appropriately in work and educational settings;~~

127.25 ~~(11) ability to understand written treatment materials, including rules and the client's~~
127.26 ~~rights;~~

127.27 ~~(12) a description of any risk-taking behavior, including behavior that puts the client at~~
127.28 ~~risk of exposure to blood-borne or sexually transmitted diseases;~~

127.29 ~~(13) social network in relation to expected support for recovery;~~

127.30 ~~(14) leisure time activities that are associated with substance use;~~

128.1 ~~(15) whether the client is pregnant and, if so, the health of the unborn child and the~~
128.2 ~~client's current involvement in prenatal care;~~

128.3 ~~(16) whether the client recognizes needs related to substance use and is willing to follow~~
128.4 ~~treatment recommendations; and~~

128.5 ~~(17) information from a collateral contact may be included, but is not required.~~

128.6 ~~(b) If the client is identified as having opioid use disorder or seeking treatment for opioid~~
128.7 ~~use disorder, the program must provide educational information to the client concerning:~~

128.8 ~~(1) risks for opioid use disorder and dependence;~~

128.9 ~~(2) treatment options, including the use of a medication for opioid use disorder;~~

128.10 ~~(3) the risk of and recognizing opioid overdose; and~~

128.11 ~~(4) the use, availability, and administration of naloxone to respond to opioid overdose.~~

128.12 ~~(c) The commissioner shall develop educational materials that are supported by research~~
128.13 ~~and updated periodically. The license holder must use the educational materials that are~~
128.14 ~~approved by the commissioner to comply with this requirement.~~

128.15 ~~(d) If the comprehensive assessment is completed to authorize treatment service for the~~
128.16 ~~client, at the earliest opportunity during the assessment interview the assessor shall determine~~
128.17 ~~if:~~

128.18 ~~(1) the client is in severe withdrawal and likely to be a danger to self or others;~~

128.19 ~~(2) the client has severe medical problems that require immediate attention; or~~

128.20 ~~(3) the client has severe emotional or behavioral symptoms that place the client or others~~
128.21 ~~at risk of harm.~~

128.22 ~~If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the~~
128.23 ~~assessment interview and follow the procedures in the program's medical services plan~~
128.24 ~~under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The~~
128.25 ~~assessment interview may resume when the condition is resolved.~~ An alcohol and drug
128.26 counselor must sign and date the comprehensive assessment review and update.

128.27 Sec. 8. Minnesota Statutes 2022, section 245G.05, is amended by adding a subdivision to
128.28 read:

128.29 Subd. 3. **Comprehensive assessment requirements.** (a) A comprehensive assessment
128.30 must meet the requirements under section 245I.10, subdivision 6, paragraphs (b) and (c).
128.31 It must also include:

129.1 (1) a diagnosis of a substance use disorder or a finding that the client does not meet the
129.2 criteria for a substance use disorder;

129.3 (2) a determination of whether the individual screens positive for co-occurring mental
129.4 health disorders using a screening tool approved by the commissioner pursuant to section
129.5 245.4863, except when the comprehensive assessment is being completed as part of a
129.6 diagnostic assessment according to section ;

129.7 (3) a risk rating and summary to support the risk ratings within each of the dimensions
129.8 listed in section 245G.05, subdivision 2; and

129.9 (4) a recommendation for 254B, the ASAM level of care identified in section 254B.19,
129.10 subdivision 1.

129.11 (b) If the individual is assessed for opioid use disorder, the program must provide
129.12 educational material to the client within 24 hours of service initiation on:

129.13 (1) risks for opioid use disorder and dependence;

129.14 (2) treatment options, including the use of a medication for opioid use disorder;

129.15 (3) the risk of recognizing opioid overdose; and

129.16 (4) the use, availability, and administration of naloxone to respond to opioid overdose;
129.17 and

129.18 (5) a risk rating and summary within each of the six dimensions as identified in section
129.19 245G.05, subdivision 2.

129.20 If the client is identified as having opioid use disorder at a later point, the education must
129.21 be provided at that point. The license holder must use the educational materials that are
129.22 approved by the commissioner to comply with this requirement.

129.23 Sec. 9. Minnesota Statutes 2022, section 245G.06, subdivision 1, is amended to read:

129.24 Subdivision 1. **General.** Each client must have a person-centered individual treatment
129.25 plan developed by an alcohol and drug counselor within ten days from the day of service
129.26 initiation for a residential program ~~and within five calendar days~~ by the end of the tenth day
129.27 on which a treatment session has been provided from the day of service initiation for a client
129.28 in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete
129.29 the individual treatment plan within 21 days from the day of service initiation. For the
129.30 purposes of these time frames, the day services are initiated is excluded when calculating
129.31 the number of days. The individual treatment plan must be signed by the client and the
129.32 alcohol and drug counselor and document the client's involvement in the development of

130.1 the plan. The individual treatment plan is developed upon the qualified staff member's dated
130.2 signature. Treatment planning must include ongoing assessment of client needs. An individual
130.3 treatment plan must be updated based on new information gathered about the client's
130.4 condition, the client's level of participation, and on whether methods identified have the
130.5 intended effect. A change to the plan must be signed by the client and the alcohol and drug
130.6 counselor. If the client chooses to have family or others involved in treatment services, the
130.7 client's individual treatment plan must include how the family or others will be involved in
130.8 the client's treatment. If a client is receiving treatment services or an assessment via telehealth
130.9 and the alcohol and drug counselor documents the reason the client's signature cannot be
130.10 obtained, the alcohol and drug counselor may document the client's verbal approval or
130.11 electronic written approval of the treatment plan or change to the treatment plan in lieu of
130.12 the client's signature.

130.13 Sec. 10. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision
130.14 to read:

130.15 Subd. 1a. **Individual treatment plan contents and process.** (a) After completing a
130.16 client's comprehensive assessment, the license holder must complete an individual treatment
130.17 plan. The license holder must:

130.18 (1) base the client's individual treatment plan on the client's comprehensive assessment;

130.19 (2) use a person-centered, culturally appropriate planning process that allows the client's
130.20 family and other natural supports to observe and participate in the client's individual treatment
130.21 services, assessments, and treatment planning;

130.22 (3) identify the client's treatment goals in relation to any or all of the applicable ASAM
130.23 six dimensions identified in section 245G.05, subdivision 2, to ensure measurable treatment
130.24 objectives, a treatment strategy, and a schedule for accomplishing the client's treatment
130.25 goals and objectives;

130.26 (4) document in the treatment plan the ASAM level of care identified in section 254B.05,
130.27 subdivision 5, paragraph (b), clause (1), that the client is receiving services under;

130.28 (5) identify the participants involved in the client's treatment planning. The client must
130.29 be a participant in the client's treatment planning. If applicable, the license holder must
130.30 document the reasons that the license holder did not involve the client's family or other
130.31 natural supports in the client's treatment planning;

130.32 (6) identify resources to refer the client to when the client's needs are to be addressed
130.33 concurrently by another provider; and

131.1 (7) identify maintenance strategy goals and methods designed to address relapse
131.2 prevention and to strengthen the client's protective factors.

131.3 Sec. 11. Minnesota Statutes 2022, section 245G.06, subdivision 3, is amended to read:

131.4 Subd. 3. **Treatment plan review.** A treatment plan review must be entered in a client's
131.5 file weekly or after each treatment service, whichever is less frequent, completed by the
131.6 alcohol and drug counselor responsible for the client's treatment plan. The review must
131.7 indicate the span of time covered by the review and each of the six dimensions listed in
131.8 section 245G.05, subdivision 2, paragraph (c). The review must:

131.9 (1) address each goal in the document client goals addressed since the last treatment
131.10 plan review and whether the identified methods to address the goals are continue to be
131.11 effective;

131.12 (2) include document monitoring of any physical and mental health problems and include
131.13 toxicology results for alcohol and substance use, when available;

131.14 (3) document the participation of others involved in the individual's treatment planning,
131.15 including when services are offered to the client's family or significant others;

131.16 (4) if changes to the treatment plan are determined to be necessary, document staff
131.17 recommendations for changes in the methods identified in the treatment plan and whether
131.18 the client agrees with the change; and

131.19 (5) include a review and evaluation of the individual abuse prevention plan according
131.20 to section 245A.65.; and

131.21 (6) document any referrals made since the previous treatment plan review.

131.22 Sec. 12. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision
131.23 to read:

131.24 Subd. 3a. **Frequency of treatment plan reviews.** (a) A license holder must ensure that
131.25 the alcohol and drug counselor responsible for a client's treatment plan completes and
131.26 documents a treatment plan review that meets the requirements of subdivision 3 in each
131.27 client's file according to the frequencies required in this subdivision. All ASAM levels
131.28 referred to in this chapter are those described in section 254B.05, subdivision 5.

131.29 (b) For a client receiving residential ASAM level 3.3 or 3.5 high-intensity services, a
131.30 treatment plan review must be completed once every 14 days.

(c) For a client receiving residential ASAM level 3.1 low-intensity services or any other residential level not listed in paragraph (b), a treatment plan review must be completed once every 30 days.

(d) For a client receiving nonresidential ASAM level 2.5 partial hospitalization services, a treatment plan review must be completed once every 14 days.

(e) For a client receiving nonresidential ASAM level 1.0 outpatient or 2.1 intensive outpatient services or any other nonresidential level not included in paragraph (d), a treatment plan review must be completed once every 30 days.

(f) For a client receiving opioid treatment program services according to section 245G.22, a treatment plan review must be completed weekly for the ten weeks following completion of the treatment plan and monthly thereafter. Treatment plan reviews must be completed more frequently when clinical needs warrant.

(g) Notwithstanding paragraphs (e) and (f), for a client in a nonresidential program with a treatment plan that clearly indicates less than five hours of skilled treatment services will be provided to the client each month, a treatment plan review must be completed once every 90 days.

Sec. 13. Minnesota Statutes 2022, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must ~~offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary~~ meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each time the client was offered an individual or group counseling service. If the individual or group counseling service was offered but not provided to the client, the license holder must document the reason the service was not provided. If the service was provided, the license holder must ensure the service is documented according to the requirements in section 245G.06, subdivision 2a .

133.1 (b) Notwithstanding the requirements of comprehensive assessments in section 245G.05,
133.2 the assessment must be completed within 21 days from the day of service initiation.

133.3 ~~(c) Notwithstanding the requirements of individual treatment plans set forth in section~~
133.4 ~~245G.06:~~

133.5 ~~(1) treatment plan contents for a maintenance client are not required to include goals~~
133.6 ~~the client must reach to complete treatment and have services terminated;~~

133.7 ~~(2) treatment plans for a client in a taper or detox status must include goals the client~~
133.8 ~~must reach to complete treatment and have services terminated; and~~

133.9 ~~(3)~~(c) Notwithstanding the treatment plan review frequencies in section 245G.06, for
133.10 the ten weeks following the day of service initiation for all new admissions, readmissions,
133.11 and transfers, a weekly treatment plan review must be documented once the treatment plan
133.12 is completed. Subsequently, the counselor must document treatment plan reviews in the six
133.13 dimensions at least once monthly or, when clinical need warrants, more frequently.

133.14 Sec. 14. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

133.15 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health
133.16 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
133.17 A standard diagnostic assessment of a client must include a face-to-face interview with a
133.18 client and a written evaluation of the client. The assessor must complete a client's standard
133.19 diagnostic assessment within the client's cultural context. An alcohol and drug counselor
133.20 may gather and document the information in paragraphs (b) and (c) when completing a
133.21 comprehensive assessment according to section 245G.05.

133.22 (b) When completing a standard diagnostic assessment of a client, the assessor must
133.23 gather and document information about the client's current life situation, including the
133.24 following information:

133.25 (1) the client's age;

133.26 (2) the client's current living situation, including the client's housing status and household
133.27 members;

133.28 (3) the status of the client's basic needs;

133.29 (4) the client's education level and employment status;

133.30 (5) the client's current medications;

134.1 (6) any immediate risks to the client's health and safety, specifically withdrawal, medical
134.2 conditions, and behavioral and emotional symptoms;

134.3 (7) the client's perceptions of the client's condition;

134.4 (8) the client's description of the client's symptoms, including the reason for the client's
134.5 referral;

134.6 (9) the client's history of mental health and substance use disorder treatment; ~~and~~

134.7 (10) cultural influences on the client~~.~~; and

134.8 (11) substance use history, if applicable, including:

134.9 (i) amounts and types of substances, frequency and duration, route of administration,
134.10 periods of abstinence, and circumstances of relapse; and

134.11 (ii) the impact to functioning when under the influence of substances, including legal
134.12 interventions.

134.13 (c) If the assessor cannot obtain the information that this paragraph requires without
134.14 retraumatizing the client or harming the client's willingness to engage in treatment, the
134.15 assessor must identify which topics will require further assessment during the course of the
134.16 client's treatment. The assessor must gather and document information related to the following
134.17 topics:

134.18 (1) the client's relationship with the client's family and other significant personal
134.19 relationships, including the client's evaluation of the quality of each relationship;

134.20 (2) the client's strengths and resources, including the extent and quality of the client's
134.21 social networks;

134.22 (3) important developmental incidents in the client's life;

134.23 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

134.24 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

134.25 (6) the client's health history and the client's family health history, including the client's
134.26 physical, chemical, and mental health history.

134.27 (d) When completing a standard diagnostic assessment of a client, an assessor must use
134.28 a recognized diagnostic framework.

134.29 (1) When completing a standard diagnostic assessment of a client who is five years of
134.30 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic

135.1 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
135.2 published by Zero to Three.

135.3 (2) When completing a standard diagnostic assessment of a client who is six years of
135.4 age or older, the assessor must use the current edition of the Diagnostic and Statistical
135.5 Manual of Mental Disorders published by the American Psychiatric Association.

135.6 (3) When completing a standard diagnostic assessment of a client who is five years of
135.7 age or younger, an assessor must administer the Early Childhood Service Intensity Instrument
135.8 (ECSII) to the client and include the results in the client's assessment.

135.9 (4) When completing a standard diagnostic assessment of a client who is six to 17 years
135.10 of age, an assessor must administer the Child and Adolescent Service Intensity Instrument
135.11 (CASII) to the client and include the results in the client's assessment.

135.12 (5) When completing a standard diagnostic assessment of a client who is 18 years of
135.13 age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria
135.14 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders
135.15 published by the American Psychiatric Association to screen and assess the client for a
135.16 substance use disorder.

135.17 (e) When completing a standard diagnostic assessment of a client, the assessor must
135.18 include and document the following components of the assessment:

135.19 (1) the client's mental status examination;

135.20 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
135.21 vulnerabilities; safety needs, including client information that supports the assessor's findings
135.22 after applying a recognized diagnostic framework from paragraph (d); and any differential
135.23 diagnosis of the client; and

135.24 (3) an explanation of: (i) how the assessor diagnosed the client using the information
135.25 from the client's interview, assessment, psychological testing, and collateral information
135.26 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
135.27 and (v) the client's responsivity factors.

135.28 (f) When completing a standard diagnostic assessment of a client, the assessor must
135.29 consult the client and the client's family about which services that the client and the family
135.30 prefer to treat the client. The assessor must make referrals for the client as to services required
135.31 by law.

136.1 Sec. 15. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision
136.2 to read:

136.3 Subd. 2a. **American Society of Addiction Medicine criteria or ASAM**
136.4 **criteria.** "American Society of Addiction Medicine criteria" or "ASAM" means the clinical
136.5 guidelines for purposes of the assessment, treatment, placement, and transfer or discharge
136.6 of individuals with substance use disorders. The ASAM criteria are contained in the current
136.7 edition of the *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and*
136.8 *Co-Occurring Conditions*.

136.9 Sec. 16. Minnesota Statutes 2022, section 254B.01, subdivision 8, is amended to read:

136.10 Subd. 8. **Recovery community organization.** "Recovery community organization"
136.11 means an independent organization led and governed by representatives of local communities
136.12 of recovery. A recovery community organization mobilizes resources within and outside
136.13 of the recovery community to increase the prevalence and quality of long-term recovery
136.14 from ~~alcohol and other drug addiction~~ substance use disorder. Recovery community
136.15 organizations provide peer-based recovery support activities such as training of recovery
136.16 peers. Recovery community organizations provide mentorship and ongoing support to
136.17 individuals dealing with a substance use disorder and connect them with the resources that
136.18 can support each person's recovery. A recovery community organization also promotes a
136.19 recovery-focused orientation in community education and outreach programming, and
136.20 organize recovery-focused policy advocacy activities to foster healthy communities and
136.21 reduce the stigma of substance use disorder.

136.22 Sec. 17. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision
136.23 to read:

136.24 Subd. 9. **Skilled treatment services.** "Skilled treatment services" has the meaning given
136.25 for the "treatment services" described in section 245G.07, subdivisions 1, paragraph (a),
136.26 clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by
136.27 qualified professionals as identified in section 245G.07, subdivision 3.

136.28 Sec. 18. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision
136.29 to read:

136.30 Subd. 11. **Comprehensive assessment.** "Comprehensive assessment" means a
136.31 person-centered, trauma-informed assessment that:

137.1 (1) is completed for a substance use disorder diagnosis, treatment planning, and
137.2 determination of client eligibility for substance use disorder treatment services;

137.3 (2) meets the requirements in section 245G.05; and

137.4 (3) is completed by an alcohol and drug counselor qualified according to section 245G.11,
137.5 subdivision 5.

137.6 Sec. 19. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

137.7 Subdivision 1. ~~**Licensure required**~~ **Eligible vendors.** (a) Programs licensed by the
137.8 commissioner are eligible vendors. Hospitals may apply for and receive licenses to be
137.9 eligible vendors, notwithstanding the provisions of section 245A.03. American Indian
137.10 programs that provide substance use disorder treatment, extended care, transitional residence,
137.11 or outpatient treatment services, and are licensed by tribal government are eligible vendors.

137.12 (b) A licensed professional in private practice as defined in section 245G.01, subdivision
137.13 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible
137.14 vendor of a comprehensive assessment and assessment summary provided according to
137.15 section 245G.05, and treatment services provided according to sections 245G.06 and
137.16 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses
137.17 (1) to (6).

137.18 (c) A county is an eligible vendor for a comprehensive assessment and assessment
137.19 summary when provided by an individual who meets the staffing credentials of section
137.20 245G.11, subdivisions 1 and 5, and completed according to the requirements of section
137.21 245G.05. A county is an eligible vendor of care coordination services when provided by an
137.22 individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and
137.23 provided according to the requirements of section 245G.07, subdivision 1, paragraph (a),
137.24 clause (5). A county is an eligible vendor of peer recovery services when the services are
137.25 provided by an individual who meets the requirements of section 245G.11, subdivision 8.

137.26 (d) A recovery community organization ~~that meets certification requirements identified~~
137.27 ~~by the commissioner~~ certified by the Board of Recovery Services under sections 254B.20
137.28 to 254B.24 is an eligible vendor of peer support services.

137.29 ~~(e)~~ Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
137.30 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or
137.31 nonresidential substance use disorder treatment or withdrawal management program by the
137.32 commissioner or by tribal government or do not meet the requirements of subdivisions 1a
137.33 and 1b are not eligible vendors.

Sec. 20. 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

140.1 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
140.2 licensed under chapter 245A as:

140.3 (A) a child care center under Minnesota Rules, chapter 9503; or

140.4 (B) a family child care home under Minnesota Rules, chapter 9502;

140.5 (2) culturally specific or culturally responsive programs as defined in section 254B.01,
140.6 subdivision 4a;

140.7 (3) disability responsive programs as defined in section 254B.01, subdivision 4b;

140.8 (4) programs that offer medical services delivered by appropriately credentialed health
140.9 care staff in an amount equal to two hours per client per week if the medical needs of the
140.10 client and the nature and provision of any medical services provided are documented in the
140.11 client file; or

140.12 (5) programs that offer services to individuals with co-occurring mental health and
140.13 substance use disorder problems if:

140.14 (i) the program meets the co-occurring requirements in section 245G.20;

140.15 (ii) 25 percent of the counseling staff are licensed mental health professionals under
140.16 section 245I.04, subdivision 2, or are students or licensing candidates under the supervision
140.17 of a licensed alcohol and drug counselor supervisor and mental health professional under
140.18 section 245I.04, subdivision 2, except that no more than 50 percent of the mental health
140.19 staff may be students or licensing candidates with time documented to be directly related
140.20 to provisions of co-occurring services;

140.21 (iii) clients scoring positive on a standardized mental health screen receive a mental
140.22 health diagnostic assessment within ten days of admission;

140.23 (iv) the program has standards for multidisciplinary case review that include a monthly
140.24 review for each client that, at a minimum, includes a licensed mental health professional
140.25 and licensed alcohol and drug counselor, and their involvement in the review is documented;

140.26 (v) family education is offered that addresses mental health and substance use disorder
140.27 and the interaction between the two; and

140.28 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
140.29 training annually.

140.30 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
140.31 that provides arrangements for off-site child care must maintain current documentation at
140.32 the substance use disorder facility of the child care provider's current licensure to provide

141.1 child care services. Programs that provide child care according to paragraph (c), clause (1),
141.2 must be deemed in compliance with the licensing requirements in section 245G.19.

141.3 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
141.4 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
141.5 in paragraph (c), clause (4), items (i) to (iv).

141.6 (f) Subject to federal approval, substance use disorder services that are otherwise covered
141.7 as direct face-to-face services may be provided via telehealth as defined in section 256B.0625,
141.8 subdivision 3b. The use of telehealth to deliver services must be medically appropriate to
141.9 the condition and needs of the person being served. Reimbursement shall be at the same
141.10 rates and under the same conditions that would otherwise apply to direct face-to-face services.

141.11 (g) For the purpose of reimbursement under this section, substance use disorder treatment
141.12 services provided in a group setting without a group participant maximum or maximum
141.13 client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one.
141.14 At least one of the attending staff must meet the qualifications as established under this
141.15 chapter for the type of treatment service provided. A recovery peer may not be included as
141.16 part of the staff ratio.

141.17 (h) Payment for outpatient substance use disorder services that are licensed according
141.18 to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless
141.19 prior authorization of a greater number of hours is obtained from the commissioner.

141.20 Sec. 21. **[254B.19] AMERICAN SOCIETY OF ADDICTION MEDICINE**
141.21 **STANDARDS OF CARE.**

141.22 Subdivision 1. **Level of care requirements.** For each client assigned an ASAM level
141.23 of care, eligible vendors must implement the standards set by the ASAM for the respective
141.24 level of care. Additionally, vendors must meet the following requirements.

141.25 (1) For ASAM level 0.5 early intervention targeting individuals who are at risk of
141.26 developing a substance-related problem but may not have a diagnosed substance use disorder,
141.27 early intervention services may include individual or group counseling, treatment
141.28 coordination, peer recovery support, screening brief intervention, and referral to treatment
141.29 provided according to section 254A.03, subdivision 3, paragraph (c).

141.30 (2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per
141.31 week of skilled treatment services and adolescents must receive up to five hours per week.
141.32 Services must be licensed according to section 245G.20 and meet requirements under section

142.1 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly
142.2 skilled treatment service hours allowable per week.

142.3 (3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours
142.4 per week of skilled treatment services and adolescents must receive six or more hours per
142.5 week. Vendors must be licensed according to section 245G.20 and must meet requirements
142.6 under section 256B.0759. Peer recovery and treatment coordination may be provided beyond
142.7 the hourly skilled treatment service hours allowable per week. If clinically indicated on the
142.8 client's treatment plan, this service may be provided in conjunction with room and board
142.9 according to section 254B.05, subdivision 1a.

142.10 (4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or
142.11 more of skilled treatment services. Services must be licensed according to section 245G.20
142.12 and must meet requirements under section 256B.0759. Level 2.5 is for clients who need
142.13 daily monitoring in a structured setting as directed by the individual treatment plan and in
142.14 accordance with the limitations in section 254B.05, subdivision 5, paragraph (h). If clinically
142.15 indicated on the client's treatment plan, this service may be provided in conjunction with
142.16 room and board according to section 254B.05, subdivision 1a.

142.17 (5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs
142.18 must provide at least 5 hours of skilled treatment services per week according to each client's
142.19 specific treatment schedule as directed by the individual treatment plan. Programs must be
142.20 licensed according to section 245G.20 and must meet requirements under section 256B.0759.

142.21 (6) For ASAM level 3.3 clinically managed population-specific high-intensity residential
142.22 clients, programs must be licensed according to section 245G.20 and must meet requirements
142.23 under section 256B.0759. Programs must have 24-hour-a-day staffing coverage. Programs
142.24 must be enrolled as a disability responsive program as described in section 254B.01,
142.25 subdivision 4b, and must specialize in serving persons with a traumatic brain injury or a
142.26 cognitive impairment so significant, and the resulting level of impairment so great, that
142.27 outpatient or other levels of residential care would not be feasible or effective. Programs
142.28 must provide, at minimum, daily skilled treatment services seven days a week according to
142.29 each client's specific treatment schedule as directed by the individual treatment plan.

142.30 (7) For ASAM level 3.5 clinically managed high-intensity residential clients, services
142.31 must be licensed according to section 245G.20 and must meet requirements under section
142.32 256B.0759. Programs must have 24-hour-a-day staffing coverage and provide, at minimum,
142.33 daily skilled treatment services seven days a week according to each client's specific treatment
142.34 schedule as directed by the individual treatment plan.

143.1 (8) For ASAM level withdrawal management 3.2 clinically managed clients, withdrawal
143.2 management must be provided according to chapter 245F.

143.3 (9) For ASAM level withdrawal management 3.7 medically monitored clients, withdrawal
143.4 management must be provided according to chapter 245F.

143.5 Subd. 2. **Patient referral arrangement agreement.** The license holder must maintain
143.6 documentation of a formal patient referral arrangement agreement for each of the following
143.7 levels of care not provided by the license holder:

143.8 (1) level 1.0 outpatient;

143.9 (2) level 2.1 intensive outpatient;

143.10 (3) level 2.5 partial hospitalization;

143.11 (4) level 3.1 clinically managed low-intensity residential;

143.12 (5) level 3.3 clinically managed population-specific high-intensity residential;

143.13 (6) level 3.5 clinically managed high-intensity residential;

143.14 (7) level withdrawal management 3.2 clinically managed residential withdrawal
143.15 management; and

143.16 (8) level withdrawal management 3.7 medically monitored inpatient withdrawal
143.17 management.

143.18 Subd. 3. **Evidence-based practices.** All services delivered within the ASAM levels of
143.19 care referenced in section 254B.19, subdivision 1, clauses (1) to (7), must have documentation
143.20 of the evidence-based practices being utilized as referenced in the most current edition of
143.21 the ASAM criteria.

143.22 Subd. 4. **Program outreach plan.** Eligible vendors providing services under ASAM
143.23 levels of care referenced in subdivision 1, clauses (2) to (7), must have a program outreach
143.24 plan. The treatment director must document a review and update the plan annually. The
143.25 program outreach plan must include treatment coordination strategies and processes to
143.26 ensure seamless transitions across the continuum of care. The plan must include how the
143.27 provider will:

143.28 (1) increase the awareness of early intervention treatment services, including but not
143.29 limited to the services defined in section 254A.03, subdivision 3, paragraph (c);

144.1 (2) coordinate, as necessary, with certified community behavioral health clinics when
144.2 a license holder is located in a geographic region served by a certified community behavioral
144.3 health clinic;

144.4 (3) establish a referral arrangement agreement with a withdrawal management program
144.5 licensed under chapter 245F when a license holder is located in a geographic region in which
144.6 a withdrawal management program is licensed under chapter 245F. If a withdrawal
144.7 management program licensed under chapter 245F is not geographically accessible, the
144.8 plan must include how the provider will address the client's need for this level of care;

144.9 (4) coordinate with inpatient acute-care hospitals, including emergency departments,
144.10 hospital outpatient clinics, urgent care centers, residential crisis settings, medical
144.11 detoxification inpatient facilities and ambulatory detoxification providers in the area served
144.12 by the provider to help transition individuals from emergency department or hospital settings
144.13 and minimize the time between assessment and treatment;

144.14 (5) develop and maintain collaboration with local county and Tribal human services
144.15 agencies; and

144.16 (6) collaborate with primary care and mental health settings.

144.17 Sec. 22. **[254B.191] EVIDENCE-BASED TRAINING.**

144.18 The commissioner must establish ongoing training opportunities for substance use
144.19 disorder treatment providers under chapter 245G to increase knowledge and develop skills
144.20 to adopt evidence-based and promising practices in substance use disorder treatment
144.21 programs. Training opportunities must support the transition to American Society of
144.22 Addiction Medicine (ASAM) standards. Training formats may include self or organizational
144.23 assessments, virtual modules, one-to-one coaching, self-paced courses, interactive hybrid
144.24 courses, and in-person courses. Foundational and skill-building training topics may include:

144.25 (1) ASAM criteria;

144.26 (2) person-centered and culturally responsive services;

144.27 (3) medical and clinical decision making;

144.28 (4) conducting assessments and appropriate level of care;

144.29 (5) treatment and service planning;

144.30 (6) identifying and overcoming systems challenges;

144.31 (7) conducting clinical case reviews; and

145.1 (8) appropriate and effective transfer and discharge.

145.2 Sec. 23. **[254B.20] DEFINITIONS.**

145.3 Subdivision 1. **Applicability.** For the purposes of sections 254B.20 to 254B.24, the
145.4 following terms have the meanings given.

145.5 Subd. 2. **Board.** "Board" means the Board of Recovery Services established by section
145.6 254B.21.

145.7 Subd. 3. **Credential or credentialing.** "Credential" or "credentialing" means the
145.8 standardized process of formally reviewing and designating a recovery organization as
145.9 qualified to employ peer recovery specialists based on criteria established by the board.

145.10 Subd. 4. **Minnesota Certification Board.** "Minnesota Certification Board" means the
145.11 nonprofit agency member board of the International Certification and Reciprocity Consortium
145.12 that sets the policies and procedures for alcohol and other drug professional certifications
145.13 in Minnesota, including peer recovery specialists.

145.14 Subd. 5. **Peer recovery specialist.** "Peer recovery specialist" has the meaning given to
145.15 "recovery peer" in section 245F.02, subdivision 21. A peer recovery specialist must meet
145.16 the qualifications of a recovery peer in section 245G.11, subdivision 8.

145.17 Subd. 6. **Peer recovery services.** "Peer recovery services" has the meaning given to
145.18 "peer recovery support services" in section 245F.02, subdivision 17.

145.19 Sec. 24. **[254B.21] MINNESOTA BOARD OF RECOVERY SERVICES.**

145.20 Subdivision 1. **Creation.** (a) The Minnesota Board of Recovery Services is established
145.21 and consists of 13 members appointed by the governor as follows:

145.22 (1) five of the members must be certified peer recovery specialists certified under the
145.23 Minnesota Certification Board with an active credential;

145.24 (2) two of the members must be certified peer recovery specialist supervisors certified
145.25 under the Minnesota Certification Board with an active credential;

145.26 (3) four of the members must be currently employed by a Minnesota-based recovery
145.27 community organization recognized by the commissioner of human services; and

145.28 (4) two of the members must be public members as defined in section 214.02, and be
145.29 either a family member of a person currently using substances or a person in recovery from
145.30 a substance use disorder.

146.1 (b) At the time of their appointments, at least three members must reside outside of the
146.2 seven-county metropolitan area.

146.3 (c) At the time of their appointments, at least three members must be members of:

146.4 (1) a community of color; or

146.5 (2) an underrepresented community, defined as a group that is not represented in the
146.6 majority with respect to race, ethnicity, national origin, sexual orientation, gender identity,
146.7 or physical ability.

146.8 Subd. 2. **Officers.** The board must annually elect a chair and vice-chair from among its
146.9 members and may elect other officers as necessary. The board must meet at least twice a
146.10 year but may meet more frequently at the call of the chair.

146.11 Subd. 3. **Membership terms; compensation.** Membership terms, compensation of
146.12 members, removal of members, the filling of membership vacancies, and fiscal year and
146.13 reporting requirements are as provided in section 15.058.

146.14 Subd. 4. **Expiration.** The board does not expire.

146.15 Sec. 25. **[254B.22] DUTIES OF THE BOARD.**

146.16 The Minnesota Board of Recovery Services shall:

146.17 (1) develop and define by rule criteria for credentialing recovery organizations using
146.18 nationally recognized best practices and standards;

146.19 (2) determine the renewal cycle and renewal period for eligible vendors of peer recovery
146.20 services;

146.21 (3) receive, review, approve, or disapprove initial applications, renewals, and
146.22 reinstatement requests for credentialing from recovery organizations;

146.23 (4) establish administrative procedures for processing applications submitted under
146.24 clause (3) and hire or appoint such agents as are appropriate for processing applications;

146.25 (5) retain records of its actions and proceedings in accordance with public records laws;

146.26 (6) establish, maintain, and publish annually a register of current credentialed recovery
146.27 organizations; and

146.28 (7) adopt any rules necessary to implement sections 254B.20 to 254B.24.

147.1 Sec. 26. **[254B.23] REQUIREMENTS FOR CREDENTIALING.**

147.2 Subdivision 1. **Application requirements.** An application submitted to the board for
147.3 credentialing must include:

147.4 (1) evidence that the applicant is a nonprofit organization based in Minnesota or meets
147.5 the eligibility criteria defined by the board;

147.6 (2) a description of the applicant's activities and services that support recovery from
147.7 substance use disorder; and

147.8 (3) any other requirements as specified by the board.

147.9 Subd. 2. **Fee.** Each applicant must pay a nonrefundable application fee as established
147.10 by the board. The revenue from the fee must be deposited in the state government special
147.11 revenue fund.

147.12 Sec. 27. **[254B.24] APPEAL AND HEARING.**

147.13 A recovery organization aggrieved by the board's failure to issue, renew, or reinstate
147.14 credentialing under sections 254B.20 to 254B.24 may appeal by requesting a hearing under
147.15 the procedures of chapter 14.

147.16 Sec. 28. **[254B.30] PROJECT ECHO GRANTS.**

147.17 Subdivision 1. **Establishment.** The commissioner must establish a grant program to
147.18 support new or existing Project ECHO programs in the state.

147.19 Subd. 2. **Project ECHO at Hennepin Healthcare.** The commissioner must use
147.20 appropriations under this subdivision to award grants to Hennepin Healthcare to establish
147.21 at least four substance use disorder-focused Project ECHO programs, expanding the grantee's
147.22 capacity to improve health and substance use disorder outcomes for diverse populations of
147.23 individuals enrolled in medical assistance, including but not limited to immigrants,
147.24 individuals who are homeless, individuals seeking maternal and perinatal care, and other
147.25 underserved populations. The Project ECHO programs funded under this subdivision must
147.26 be culturally responsive, and the grantee must contract with culturally and linguistically
147.27 appropriate substance use disorder service providers who have expertise in focus areas,
147.28 based on the populations served. Grant funds may be used for program administration,
147.29 equipment, provider reimbursement, and staffing hours.

Sec. 29. 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. 30. Minnesota Statutes 2022, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) ~~Outpatient~~ Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment ~~providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider~~ programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter and are licensed as a hospital under sections 144.50 to 144.581 must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025.

~~(c)~~(d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

~~(d)~~(e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the

149.1 requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements
149.2 of this paragraph are ineligible for payment for services provided under section 256B.0625.

149.3 ~~(e)~~(f) Tribally licensed programs may elect to participate in the demonstration project
149.4 and meet the requirements of subdivision 3. The Department of Human Services must
149.5 consult with Tribal nations to discuss participation in the substance use disorder
149.6 demonstration project.

149.7 ~~(f)~~(g) The commissioner shall allow providers enrolled in the demonstration project
149.8 before July 1, 2021, to receive applicable rate enhancements authorized under subdivision
149.9 4 for all services provided on or after the date of enrollment, except that the commissioner
149.10 shall allow a provider to receive applicable rate enhancements authorized under subdivision
149.11 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after
149.12 January 1, 2021, to managed care enrollees, if the provider meets all of the following
149.13 requirements:

149.14 (1) the provider attests that during the time period for which the provider is seeking the
149.15 rate enhancement, the provider took meaningful steps in their plan approved by the
149.16 commissioner to meet the demonstration project requirements in subdivision 3; and

149.17 (2) the provider submits attestation and evidence, including all information requested
149.18 by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in
149.19 a format required by the commissioner.

149.20 ~~(g)~~(h) The commissioner may recoup any rate enhancements paid under paragraph ~~(f)~~(g)
149.21 to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

149.22 Sec. 31. Minnesota Statutes 2022, section 256I.05, is amended by adding a subdivision
149.23 to read:

149.24 Subd. 1s. **Supplemental rate; Douglas County.** Notwithstanding the provisions of
149.25 subdivisions 1a and 1c, beginning July 1, 2023, a county agency shall negotiate a
149.26 supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per
149.27 month, including any legislatively authorized inflationary adjustments, for a housing support
149.28 provider located in Douglas County that operates a long-term residential facility with a total
149.29 of 74 beds that serve chemically dependent men and provide 24-hour-a-day supervision
149.30 and other support services.

150.1 Sec. 32. **[325F.725] SOBER HOME TITLE PROTECTION.**

150.2 No person or entity may use the phrase "sober home," whether alone or in combination
150.3 with other words and whether orally or in writing, to advertise, market, or otherwise describe,
150.4 offer, or promote itself, or any housing, service, service package, or program that it provides
150.5 within this state, unless the person or entity is a cooperative living residence, a room and
150.6 board residence, an apartment, or any other living accommodation that provides temporary
150.7 housing to persons with a substance use disorder, does not provide counseling or treatment
150.8 services to residents, promotes sustained recovery from substance use disorders, and follows
150.9 the sober living guidelines published by the federal Substance Abuse and Mental Health
150.10 Services Administration.

150.11 Sec. 33. **CULTURALLY RESPONSIVE RECOVERY COMMUNITY GRANTS.**

150.12 The commissioner must establish start-up and capacity-building grants for prospective
150.13 or new recovery community organizations serving or intending to serve culturally specific
150.14 or population-specific recovery communities. Grants may be used for expenses that are not
150.15 reimbursable under Minnesota health care programs, including but not limited to:

150.16 (1) costs associated with hiring and retaining staff;

150.17 (2) staff training, purchasing office equipment and supplies;

150.18 (3) purchasing software and website services;

150.19 (4) costs associated with establishing nonprofit status;

150.20 (5) rental and lease costs and community outreach; and

150.21 (6) education and recovery events.

150.22 **EFFECTIVE DATE.** This section is effective July 1, 2023.

150.23 Sec. 34. **WITHDRAWAL MANAGEMENT START-UP AND**
150.24 **CAPACITY-BUILDING GRANTS.**

150.25 The commissioner must establish start-up and capacity-building grants for prospective
150.26 or new withdrawal management programs that will meet medically monitored or clinically
150.27 monitored levels of care. Grants may be used for expenses that are not reimbursable under
150.28 Minnesota health care programs, including but not limited to:

150.29 (1) costs associated with hiring staff;

150.30 (2) costs associated with staff retention;

151.1 (3) the purchase of office equipment and supplies;

151.2 (4) the purchase of software;

151.3 (5) costs associated with obtaining applicable and required licenses;

151.4 (6) business formation costs;

151.5 (7) costs associated with staff training; and

151.6 (8) the purchase of medical equipment and supplies necessary to meet health and safety
151.7 requirements.

151.8 **EFFECTIVE DATE.** This section is effective July 1, 2023.

151.9 Sec. 35. **FAMILY TREATMENT START-UP AND CAPACITY-BUILDING**
151.10 **GRANTS.**

151.11 The commissioner must establish start-up and capacity-building grants for prospective
151.12 or new substance use disorder treatment programs that serve parents with their children.
151.13 Grants must be used for expenses that are not reimbursable under Minnesota health care
151.14 programs, including but not limited to:

151.15 (1) physical plant upgrades to support larger family units;

151.16 (2) supporting the expansion or development of programs that provide holistic services,
151.17 including trauma supports, conflict resolution, and parenting skills;

151.18 (3) increasing awareness, education, and outreach utilizing culturally responsive
151.19 approaches to develop relationships between culturally specific communities and clinical
151.20 treatment provider programs; and

151.21 (4) expanding culturally specific family programs and accommodating diverse family
151.22 units.

151.23 **EFFECTIVE DATE.** This section is effective July 1, 2023.

151.24 Sec. 36. **MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM**
151.25 **TRANSFORMATION STUDY.**

151.26 The commissioner, in consultation with stakeholders, must evaluate the feasibility,
151.27 potential design, and federal authorities needed to cover traditional healing, behavioral
151.28 health services in correctional facilities, and contingency management under the medical
151.29 assistance program.

152.1 Sec. 37. **REVISED PAYMENT METHODOLOGY FOR OPIOID TREATMENT**
152.2 **PROGRAMS.**

152.3 The commissioner must revise the payment methodology for substance use services
152.4 with medications for opioid use disorder under Minnesota Statutes, section 254B.05,
152.5 subdivision 5, paragraph (b), clause (6). Payment must occur only if the provider renders
152.6 the service or services billed on that date of service or, in the case of drugs and drug-related
152.7 services, within a week as defined by the commissioner. The revised payment methodology
152.8 must include a weekly bundled rate that includes the costs of drugs, drug administration
152.9 and observation, drug packaging and preparation, and nursing time. The bundled weekly
152.10 rate must be based on the Medicare rate. The commissioner must seek all necessary waivers,
152.11 state plan amendments, and federal authorities required to implement the revised payment
152.12 methodology.

152.13 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,
152.14 whichever is later. The commissioner of human services shall notify the revisor of statutes
152.15 when federal approval is obtained.

152.16 Sec. 38. **REVISOR INSTRUCTION.**

152.17 The revisor of statutes shall renumber Minnesota Statutes, section 245G.01, subdivision
152.18 20b, as Minnesota Statutes, section 245G.01, subdivision 20d, and make any necessary
152.19 changes to cross-references.

152.20 Sec. 39. **REPEALER.**

152.21 (a) Minnesota Statutes 2022, sections 245G.06, subdivision 2; and 256B.0759, subdivision
152.22 6, are repealed.

152.23 (b) Minnesota Statutes 2022, section 246.18, subdivisions 2 and 2a, are repealed.

152.24 **EFFECTIVE DATE.** Paragraph (a) is effective August 1, 2023. Paragraph (b) is effective
152.25 July 1, 2023.

152.26 **ARTICLE 5**
152.27 **SUBSTANCE USE DISORDER**

152.28 Section 1. **[121A.224] OPIATE ANTAGONISTS.**

152.29 (a) A school district or charter school must maintain a supply of opiate antagonists, as
152.30 defined in section 604A.04, subdivision 1, at each school site to be administered in
152.31 compliance with section 151.37, subdivision 12.

153.1 (b) Each school building must have two doses of nasal naloxone available on site.

153.2 (c) The commissioner of health must develop and disseminate to schools a short training
153.3 video about how and when to administer nasal naloxone. The person having control of the
153.4 school building must ensure that at least one staff member trained on how and when to
153.5 administer nasal naloxone is on site when the school building is open to students, staff, or
153.6 the public, including before school, after school, or weekend activities.

153.7 **EFFECTIVE DATE.** This section is effective July 1, 2023.

153.8 Sec. 2. Minnesota Statutes 2022, section 151.065, subdivision 7, is amended to read:

153.9 Subd. 7. **Deposit of fees.** (a) The license fees collected under this section, with the
153.10 exception of the fees identified in paragraphs (b) and (c), shall be deposited in the state
153.11 government special revenue fund.

153.12 (b) $5,000 of each fee collected under subdivision 1, clauses (6) to (9), and (11) to (15),
153.13 and subdivision 3, clauses (4) to (7), and (9) to (13), and $55,000 of each fee collected under
153.14 subdivision 1, clause (16), and subdivision 3, clause (14), shall be deposited in the opiate
153.15 epidemic response fund established in section 256.043.

153.16 ~~(c) If the fees collected under subdivision 1, clause (16), or subdivision 3, clause (14),~~
153.17 ~~are reduced under section 256.043, $5,000 of the reduced fee shall be deposited in the opiate~~
153.18 ~~epidemic response fund in section 256.043.~~

153.19 Sec. 3. Minnesota Statutes 2022, section 241.021, subdivision 1, is amended to read:

153.20 Subdivision 1. **Correctional facilities; inspection; licensing.** (a) Except as provided
153.21 in paragraph (b), the commissioner of corrections shall inspect and license all correctional
153.22 facilities throughout the state, whether public or private, established and operated for the
153.23 detention and confinement of persons confined or incarcerated therein according to law
153.24 except to the extent that they are inspected or licensed by other state regulating agencies.
153.25 The commissioner shall promulgate pursuant to chapter 14, rules establishing minimum
153.26 standards for these facilities with respect to their management, operation, physical condition,
153.27 and the security, safety, health, treatment, and discipline of persons confined or incarcerated
153.28 therein. These minimum standards shall include but are not limited to specific guidance
153.29 pertaining to:

153.30 (1) screening, appraisal, assessment, and treatment for persons confined or incarcerated
153.31 in correctional facilities with mental illness or substance use disorders;

153.32 (2) a policy on the involuntary administration of medications;

154.1 (3) suicide prevention plans and training;

154.2 (4) verification of medications in a timely manner;

154.3 (5) well-being checks;

154.4 (6) discharge planning, including providing prescribed medications to persons confined
154.5 or incarcerated in correctional facilities upon release;

154.6 (7) a policy on referrals or transfers to medical or mental health care in a noncorrectional
154.7 institution;

154.8 (8) use of segregation and mental health checks;

154.9 (9) critical incident debriefings;

154.10 (10) clinical management of substance use disorders and opioid overdose emergency
154.11 procedures;

154.12 (11) a policy regarding identification of persons with special needs confined or
154.13 incarcerated in correctional facilities;

154.14 (12) a policy regarding the use of telehealth;

154.15 (13) self-auditing of compliance with minimum standards;

154.16 (14) information sharing with medical personnel and when medical assessment must be
154.17 facilitated;

154.18 (15) a code of conduct policy for facility staff and annual training;

154.19 (16) a policy on death review of all circumstances surrounding the death of an individual
154.20 committed to the custody of the facility; and

154.21 (17) dissemination of a rights statement made available to persons confined or
154.22 incarcerated in licensed correctional facilities.

154.23 No individual, corporation, partnership, voluntary association, or other private
154.24 organization legally responsible for the operation of a correctional facility may operate the
154.25 facility unless it possesses a current license from the commissioner of corrections. Private
154.26 adult correctional facilities shall have the authority of section 624.714, subdivision 13, if
154.27 the Department of Corrections licenses the facility with the authority and the facility meets
154.28 requirements of section 243.52.

154.29 The commissioner shall review the correctional facilities described in this subdivision
154.30 at least once every two years, except as otherwise provided, to determine compliance with

155.1 the minimum standards established according to this subdivision or other Minnesota statute
155.2 related to minimum standards and conditions of confinement.

155.3 The commissioner shall grant a license to any facility found to conform to minimum
155.4 standards or to any facility which, in the commissioner's judgment, is making satisfactory
155.5 progress toward substantial conformity and the standards not being met do not impact the
155.6 interests and well-being of the persons confined or incarcerated in the facility. A limited
155.7 license under subdivision 1a may be issued for purposes of effectuating a facility closure.
155.8 The commissioner may grant licensure up to two years. Unless otherwise specified by
155.9 statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the
155.10 expiration date stated on the license.

155.11 The commissioner shall have access to the buildings, grounds, books, records, staff, and
155.12 to persons confined or incarcerated in these facilities. The commissioner may require the
155.13 officers in charge of these facilities to furnish all information and statistics the commissioner
155.14 deems necessary, at a time and place designated by the commissioner.

155.15 All facility administrators of correctional facilities are required to report all deaths of
155.16 individuals who died while committed to the custody of the facility, regardless of whether
155.17 the death occurred at the facility or after removal from the facility for medical care stemming
155.18 from an incident or need for medical care at the correctional facility, as soon as practicable,
155.19 but no later than 24 hours of receiving knowledge of the death, including any demographic
155.20 information as required by the commissioner.

155.21 All facility administrators of correctional facilities are required to report all other
155.22 emergency or unusual occurrences as defined by rule, including uses of force by facility
155.23 staff that result in substantial bodily harm or suicide attempts, to the commissioner of
155.24 corrections within ten days from the occurrence, including any demographic information
155.25 as required by the commissioner. The commissioner of corrections shall consult with the
155.26 Minnesota Sheriffs' Association and a representative from the Minnesota Association of
155.27 Community Corrections Act Counties who is responsible for the operations of an adult
155.28 correctional facility to define "use of force" that results in substantial bodily harm for
155.29 reporting purposes.

155.30 The commissioner may require that any or all such information be provided through the
155.31 Department of Corrections detention information system. The commissioner shall post each
155.32 inspection report publicly and on the department's website within 30 days of completing
155.33 the inspection. The education program offered in a correctional facility for the confinement

156.1 or incarceration of juvenile offenders must be approved by the commissioner of education
156.2 before the commissioner of corrections may grant a license to the facility.

156.3 (b) For juvenile facilities licensed by the commissioner of human services, the
156.4 commissioner may inspect and certify programs based on certification standards set forth
156.5 in Minnesota Rules. For the purpose of this paragraph, "certification" has the meaning given
156.6 it in section 245A.02.

156.7 (c) Any state agency which regulates, inspects, or licenses certain aspects of correctional
156.8 facilities shall, insofar as is possible, ensure that the minimum standards it requires are
156.9 substantially the same as those required by other state agencies which regulate, inspect, or
156.10 license the same aspects of similar types of correctional facilities, although at different
156.11 correctional facilities.

156.12 (d) Nothing in this section shall be construed to limit the commissioner of corrections'
156.13 authority to promulgate rules establishing standards of eligibility for counties to receive
156.14 funds under sections 401.01 to 401.16, or to require counties to comply with operating
156.15 standards the commissioner establishes as a condition precedent for counties to receive that
156.16 funding.

156.17 (e) The department's inspection unit must report directly to a division head outside of
156.18 the correctional institutions division.

156.19 Sec. 4. Minnesota Statutes 2022, section 241.31, subdivision 5, is amended to read:

156.20 Subd. 5. **Minimum standards.** The commissioner of corrections shall establish minimum
156.21 standards for the size, area to be served, qualifications of staff, ratio of staff to client
156.22 population, and treatment programs for community corrections programs established pursuant
156.23 to this section. Plans and specifications for such programs, including proposed budgets must
156.24 first be submitted to the commissioner for approval prior to the establishment. Community
156.25 corrections programs must maintain a supply of opiate antagonists, as defined in section
156.26 604A.04, subdivision 1, at each correctional site to be administered in compliance with
156.27 section 151.37, subdivision 12. Each site must have at least two doses of naloxone on site.
156.28 Staff must be trained on how and when to administer opiate antagonists.

156.29 Sec. 5. Minnesota Statutes 2022, section 241.415, is amended to read:

156.30 **241.415 RELEASE PLANS; SUBSTANCE ABUSE.**

156.31 The commissioner shall cooperate with community-based corrections agencies to
156.32 determine how best to address the substance abuse treatment needs of offenders who are

157.1 being released from prison. The commissioner shall ensure that an offender's prison release
157.2 plan adequately addresses the offender's needs for substance abuse assessment, treatment,
157.3 or other services following release, within the limits of available resources. The commissioner
157.4 must provide individuals with known or stated histories of opioid use disorder with
157.5 emergency opiate antagonist rescue kits upon release.

157.6 Sec. 6. **[245.89] PUBLIC AWARENESS CAMPAIGN.**

157.7 (a) The commissioner must establish an ongoing, multitiered public awareness and
157.8 educational campaign on substance use disorders. The campaign must include strategies to
157.9 prevent substance use disorder, reduce stigma, and ensure people know how to access
157.10 treatment, recovery, and harm reduction services.

157.11 (b) The commissioner must consult with communities disproportionately impacted by
157.12 substance use disorder to ensure the campaign centers lived experience and equity. The
157.13 commissioner may also consult with and establish relationships with media and
157.14 communication experts, behavioral health professionals, state and local agencies, and
157.15 community organizations to design and implement the campaign.

157.16 (c) The campaign must include awareness-raising and educational information using
157.17 multichannel marketing strategies, social media, virtual events, press releases, reports, and
157.18 targeted outreach. The commissioner must evaluate the effectiveness of the campaign and
157.19 modify outreach and strategies as needed.

157.20 Sec. 7. **[245.891] OVERDOSE SURGE ALERT SYSTEM.**

157.21 The commissioner must establish a statewide overdose surge text message alert system.
157.22 The system may include other forms of electronic alerts. The purpose of the system is to
157.23 prevent opioid overdose by cautioning people to refrain from substance use or to use
157.24 harm-reduction strategies when there is an overdose surge in the surrounding area. The
157.25 commissioner may collaborate with local agencies, other state agencies, and harm-reduction
157.26 organizations to promote and improve the voluntary text service.

157.27 Sec. 8. **[245.892] HARM REDUCTION AND CULTURALLY SPECIFIC GRANTS.**

157.28 (a) The commissioner must establish grants for Tribal Nations or culturally specific
157.29 organizations to enhance and expand capacity to address the impacts of the opioid epidemic
157.30 in their respective communities. Grants may be used to purchase and distribute harm
157.31 reduction supplies, develop organizational capacity, and expand culturally specific services.

158.1 (b) Harm reduction grant funds must be used to promote safer practices and reduce the
158.2 transmission of infectious disease. Allowable expenses include fentanyl testing supplies,
158.3 disinfectants, naloxone rescue kits, sharps disposal, wound care supplies, medication lock
158.4 boxes, FDA-approved home testing kits for viral hepatitis and HIV, and written educational
158.5 and resource materials.

158.6 (c) Culturally specific organizational capacity grant funds must be used to develop and
158.7 improve organizational infrastructure to increase access to culturally specific services and
158.8 community building. Allowable expenses include funds for organizations to hire staff or
158.9 consultants who specialize in fundraising, grant writing, business development, and program
158.10 integrity or other identified organizational needs as approved by the commissioner.

158.11 (d) Culturally specific service grant funds must be used to expand culturally specific
158.12 outreach and services. Allowable expenses include hiring or consulting with cultural advisors,
158.13 resources to support cultural traditions, and education to empower, develop a sense of
158.14 community, and develop a connection to ancestral roots.

158.15 Sec. 9. Minnesota Statutes 2022, section 245G.08, subdivision 3, is amended to read:

158.16 Subd. 3. ~~**Standing order protocol**~~ **Emergency overdose treatment.** A license holder
158.17 ~~that maintains~~ must maintain a supply of ~~naloxone~~ opiate antagonists as defined in section
158.18 604A.04, subdivision 1, available for emergency treatment of opioid overdose ~~must~~ and
158.19 may have a written standing order protocol by a physician who is licensed under chapter
158.20 147, advanced practice registered nurse who is licensed under chapter 148, or physician
158.21 assistant who is licensed under chapter 147A, that permits the license holder to maintain a
158.22 supply of naloxone on site. A license holder must require staff to undergo training in the
158.23 specific mode of administration used at the program, which may include intranasal
158.24 administration, intramuscular injection, or both.

158.25 Sec. 10. Minnesota Statutes 2022, section 256.043, subdivision 3, is amended to read:

158.26 Subd. 3. **Appropriations from registration and license fee account.** (a) The
158.27 appropriations in paragraphs (b) to ~~(h)~~ (k) shall be made from the registration and license
158.28 fee account on a fiscal year basis in the order specified.

158.29 (b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs
158.30 (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be
158.31 made accordingly.

159.1 (c) $100,000 is appropriated to the commissioner of human services for grants for
159.2 overdose antagonist distribution. Grantees may utilize funds for opioid overdose prevention,
159.3 community asset mapping, education, and overdose antagonist distribution.

159.4 (d) $2,000,000 is appropriated to the commissioner of human services for grants to Tribal
159.5 nations and five urban Indian communities for traditional healing practices for American
159.6 Indians and to increase the capacity of culturally specific providers in the behavioral health
159.7 workforce.

159.8 (e) $277,000 in fiscal year 2024 and $321,000 each year thereafter is appropriated to
159.9 the commissioner of human services to administer the funding distribution and reporting
159.10 requirements in paragraph (j).

159.11 ~~(c)~~ (f) $300,000 is appropriated to the commissioner of management and budget for
159.12 evaluation activities under section 256.042, subdivision 1, paragraph (c).

159.13 ~~(d)~~ (g) $249,000 ~~is~~ in fiscal year 2023, $375,000 in fiscal year 2024, and $315,000 each
159.14 year thereafter are appropriated to the commissioner of human services for the provision
159.15 of administrative services to the Opiate Epidemic Response Advisory Council and for the
159.16 administration of the grants awarded under paragraph ~~(h)~~ (k).

159.17 ~~(e)~~ (h) $126,000 is appropriated to the Board of Pharmacy for the collection of the
159.18 registration fees under section 151.066.

159.19 ~~(f)~~ (i) $672,000 is appropriated to the commissioner of public safety for the Bureau of
159.20 Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies
159.21 and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

159.22 ~~(g)~~ (j) After the appropriations in paragraphs (b) to ~~(f)~~ (i) are made, 50 percent of the
159.23 remaining amount is appropriated to the commissioner of human services for distribution
159.24 to county social service agencies and Tribal social service agency initiative projects
159.25 authorized under section 256.01, subdivision 14b, to provide child protection services to
159.26 children and families who are affected by addiction. The commissioner shall distribute this
159.27 money proportionally to county social service agencies and Tribal social service agency
159.28 initiative projects based on out-of-home placement episodes where parental drug abuse is
159.29 the primary reason for the out-of-home placement using data from the previous calendar
159.30 year. County social service agencies and Tribal social service agency initiative projects
159.31 receiving funds from the opiate epidemic response fund must annually report to the
159.32 commissioner on how the funds were used to provide child protection services, including
159.33 measurable outcomes, as determined by the commissioner. County social service agencies
159.34 and Tribal social service agency initiative projects must not use funds received under this

paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

~~(h)~~ (k) After the appropriations in paragraphs (b) to ~~(g)~~ (j) are made, the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

~~(i)~~ (l) Beginning in fiscal year 2022 and each year thereafter, funds for county social service agencies and Tribal social service agency initiative projects under paragraph ~~(g)~~ (j) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph ~~(h)~~ (k) may be distributed on a calendar year basis.

(m) Notwithstanding section 16A.28, funds appropriated in paragraphs (c), (d), (j), and (k) are available for up to three years.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. Minnesota Statutes 2022, section 256.043, subdivision 3a, is amended to read:

Subd. 3a. **Appropriations from settlement account.** (a) The appropriations in paragraphs (b) to (e) shall be made from the settlement account on a fiscal year basis in the order specified.

(b) If the balance in the registration and license fee account is not sufficient to fully fund the appropriations specified in subdivision 3, paragraphs (b) to (f), an amount necessary to meet any insufficiency shall be transferred from the settlement account to the registration and license fee account to fully fund the required appropriations.

(c) $209,000 in fiscal year 2023 and $239,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services for the administration of grants awarded under paragraph (e). $276,000 in fiscal year 2023 and $151,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services to collect, collate, and report data submitted and to monitor compliance with reporting and settlement expenditure requirements by grantees awarded grants under this section and municipalities receiving direct payments from a statewide opioid settlement agreement as defined in section 256.042, subdivision 6.

(d) After any appropriations necessary under paragraphs (b) and (c) are made, an amount equal to the calendar year allocation to Tribal social service agency initiative projects under subdivision 3, paragraph (g), is appropriated from the settlement account to the commissioner of human services for distribution to Tribal social service agency initiative projects to

161.1 provide child protection services to children and families who are affected by addiction.
161.2 The requirements related to proportional distribution, annual reporting, and maintenance
161.3 of effort specified in subdivision 3, paragraph (g), also apply to the appropriations made
161.4 under this paragraph.

161.5 (e) After making the appropriations in paragraphs (b), (c), and (d), the remaining amount
161.6 in the account is appropriated to the commissioner of human services to award grants as
161.7 specified by the Opiate Epidemic Response Advisory Council in accordance with section
161.8 256.042.

161.9 (f) Funds for Tribal social service agency initiative projects under paragraph (d) and
161.10 grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph
161.11 (e) may be distributed on a calendar year basis.

161.12 (g) Notwithstanding section 16A.28, funds appropriated in paragraphs (d) and (e) are
161.13 available for three years.

161.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

161.15 Sec. 12. **[256I.052] OPIATE ANTAGONISTS.**

161.16 (a) Site-based or group housing support settings must maintain a supply of opiate
161.17 antagonists as defined in section 604A.04, subdivision 1, at each housing site to be
161.18 administered in compliance with section 151.37, subdivision 12.

161.19 (b) Each site must have at least two doses of naloxone on site.

161.20 (c) Staff on site must have training on how and when to administer opiate antagonists.

161.21 Sec. 13. Laws 2019, chapter 63, article 3, section 1, as amended by Laws 2020, chapter
161.22 115, article 3, section 35, and Laws 2022, chapter 53, section 12, is amended to read:

161.23 Section 1. **APPROPRIATIONS.**

161.24 (a) **Board of Pharmacy; administration.** $244,000 in fiscal year 2020 is appropriated
161.25 from the general fund to the Board of Pharmacy for onetime information technology and
161.26 operating costs for administration of licensing activities under Minnesota Statutes, section
161.27 151.066. This is a onetime appropriation.

161.28 (b) **Commissioner of human services; administration.** $309,000 in fiscal year 2020
161.29 is appropriated from the general fund and $60,000 in fiscal year 2021 is appropriated from
161.30 the opiate epidemic response fund to the commissioner of human services for the provision
161.31 of administrative services to the Opiate Epidemic Response Advisory Council and for the

administration of the grants awarded under paragraphs (f), (g), and (h). The opiate epidemic response fund base for this appropriation is $60,000 in fiscal year 2022, $60,000 in fiscal year 2023, $60,000 in fiscal year 2024, and $0 in fiscal year 2025.

(c) **Board of Pharmacy; administration.** $126,000 in fiscal year 2020 is appropriated from the general fund to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(d) **Commissioner of public safety; enforcement activities.** $672,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(e) **Commissioner of management and budget; evaluation activities.** $300,000 in fiscal year 2020 is appropriated from the general fund and $300,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of management and budget for evaluation activities under Minnesota Statutes, section 256.042, subdivision 1, paragraph (c).

(f) **Commissioner of human services; grants for Project ECHO.** $400,000 in fiscal year 2020 is appropriated from the general fund and $400,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for grants of $200,000 to CHI St. Gabriel's Health Family Medical Center for the opioid-focused Project ECHO program and $200,000 to Hennepin Health Care for the opioid-focused Project ECHO program. The opiate epidemic response fund base for this appropriation is $400,000 in fiscal year 2022, $400,000 in fiscal year 2023, $400,000 in fiscal year 2024, and $0 in fiscal year 2025.

(g) **Commissioner of human services; opioid overdose prevention grant.** $100,000 in fiscal year 2020 is appropriated from the general fund and $100,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for a grant to a nonprofit organization that has provided overdose prevention programs to the public in at least 60 counties within the state, for at least three years, has received federal funding before January 1, 2019, and is dedicated to addressing the opioid epidemic. The grant must be used for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution. ~~The opiate epidemic response fund base for this appropriation is $100,000 in fiscal year 2022, $100,000 in fiscal year 2023, $100,000 in fiscal year 2024, and $0 in fiscal year 2025.~~

163.1 (h) **Commissioner of human services; traditional healing.** $2,000,000 in fiscal year
163.2 2020 is appropriated from the general fund and $2,000,000 in fiscal year 2021 is appropriated
163.3 from the opiate epidemic response fund to the commissioner of human services to award
163.4 grants to Tribal nations and five urban Indian communities for traditional healing practices
163.5 to American Indians and to increase the capacity of culturally specific providers in the
163.6 behavioral health workforce. ~~The opiate epidemic response fund base for this appropriation~~
163.7 ~~is $2,000,000 in fiscal year 2022, $2,000,000 in fiscal year 2023, $2,000,000 in fiscal year~~
163.8 ~~2024, and $0 in fiscal year 2025.~~

163.9 (i) **Board of Dentistry; continuing education.** $11,000 in fiscal year 2020 is
163.10 appropriated from the state government special revenue fund to the Board of Dentistry to
163.11 implement the continuing education requirements under Minnesota Statutes, section 214.12,
163.12 subdivision 6.

163.13 (j) **Board of Medical Practice; continuing education.** $17,000 in fiscal year 2020 is
163.14 appropriated from the state government special revenue fund to the Board of Medical Practice
163.15 to implement the continuing education requirements under Minnesota Statutes, section
163.16 214.12, subdivision 6.

163.17 (k) **Board of Nursing; continuing education.** $17,000 in fiscal year 2020 is appropriated
163.18 from the state government special revenue fund to the Board of Nursing to implement the
163.19 continuing education requirements under Minnesota Statutes, section 214.12, subdivision
163.20 6.

163.21 (l) **Board of Optometry; continuing education.** $5,000 in fiscal year 2020 is
163.22 appropriated from the state government special revenue fund to the Board of Optometry to
163.23 implement the continuing education requirements under Minnesota Statutes, section 214.12,
163.24 subdivision 6.

163.25 (m) **Board of Podiatric Medicine; continuing education.** $5,000 in fiscal year 2020
163.26 is appropriated from the state government special revenue fund to the Board of Podiatric
163.27 Medicine to implement the continuing education requirements under Minnesota Statutes,
163.28 section 214.12, subdivision 6.

163.29 (n) **Commissioner of health; nonnarcotic pain management and wellness.** $1,250,000
163.30 is appropriated in fiscal year 2020 from the general fund to the commissioner of health, to
163.31 provide funding for:

163.32 (1) statewide mapping and assessment of community-based nonnarcotic pain management
163.33 and wellness resources; and

164.1 (2) up to five demonstration projects in different geographic areas of the state to provide
164.2 community-based nonnarcotic pain management and wellness resources to patients and
164.3 consumers.

164.4 The demonstration projects must include an evaluation component and scalability analysis.
164.5 The commissioner shall award the grant for the statewide mapping and assessment, and the
164.6 demonstration project grants, through a competitive request for proposal process. Grants
164.7 for statewide mapping and assessment and demonstration projects may be awarded
164.8 simultaneously. In awarding demonstration project grants, the commissioner shall give
164.9 preference to proposals that incorporate innovative community partnerships, are informed
164.10 and led by people in the community where the project is taking place, and are culturally
164.11 relevant and delivered by culturally competent providers. This is a onetime appropriation.

164.12 (o) **Commissioner of health; administration.** $38,000 in fiscal year 2020 is appropriated
164.13 from the general fund to the commissioner of health for the administration of the grants
164.14 awarded in paragraph (n).

164.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

164.16 Sec. 14. **OPIATE ANTAGONIST TRAINING GRANTS.**

164.17 The commissioner must establish grants to support training on how to safely store opiate
164.18 antagonists, opioid overdose symptoms and identification, and how and when to administer
164.19 opiate antagonists. Eligible grantees include correctional facilities or programs, housing
164.20 programs, and substance use disorder programs.

164.21 **ARTICLE 6**

164.22 **OPIOID PRESCRIBING IMPROVEMENT PROGRAM**

164.23 Section 1. Minnesota Statutes 2022, section 256B.0638, subdivision 1, is amended to read:

164.24 Subdivision 1. **Program established.** The commissioner of human services, in
164.25 conjunction with the commissioner of health, shall coordinate and implement an opioid
164.26 prescribing improvement program to reduce opioid dependency and substance use by
164.27 Minnesotans due to the prescribing of opioid analgesics by health care providers and to
164.28 support patient-centered, compassionate care for Minnesotans who require treatment with
164.29 opioid analgesics.

165.1 Sec. 2. Minnesota Statutes 2022, section 256B.0638, subdivision 2, is amended to read:

165.2 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision
165.3 have the meanings given them.

165.4 (b) "Commissioner" means the commissioner of human services.

165.5 (c) "Commissioners" means the commissioner of human services and the commissioner
165.6 of health.

165.7 (d) "DEA" means the United States Drug Enforcement Administration.

165.8 (e) "Minnesota health care program" means a public health care program administered
165.9 by the commissioner of human services under this chapter and chapter 256L, and the
165.10 Minnesota restricted recipient program.

165.11 (f) "Opioid ~~disenrollment~~ sanction standards" means ~~parameters~~ clinical indicators
165.12 defined by the Opioid Prescribing Work Group of opioid prescribing practices that fall
165.13 outside community standard thresholds for prescribing to such a degree that a provider ~~must~~
165.14 ~~be disenrolled~~ may be subject to sanctions under section 256B.064 as a ~~medical assistance~~
165.15 Minnesota health care program provider.

165.16 (g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to
165.17 ~~medical assistance~~ Minnesota health care program and MinnesotaCare enrollees under the
165.18 fee-for-service system or under a managed care or county-based purchasing plan.

165.19 (h) "Opioid quality improvement standard thresholds" means parameters of opioid
165.20 prescribing practices that fall outside community standards for prescribing to such a degree
165.21 that quality improvement is required.

165.22 (i) "Program" means the statewide opioid prescribing improvement program established
165.23 under this section.

165.24 (j) "Provider group" means a clinic, hospital, or primary or specialty practice group that
165.25 employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not
165.26 include a professional association supported by dues-paying members.

165.27 (k) "Sentinel measures" means measures of opioid use that identify variations in
165.28 prescribing practices during the prescribing intervals.

166.1 Sec. 3. Minnesota Statutes 2022, section 256B.0638, subdivision 4, is amended to read:

166.2 Subd. 4. **Program components.** (a) The working group shall recommend to the
166.3 commissioners the components of the statewide opioid prescribing improvement program,
166.4 including, but not limited to, the following:

166.5 (1) developing criteria for opioid prescribing protocols, including:

166.6 (i) prescribing for the interval of up to four days immediately after an acute painful
166.7 event;

166.8 (ii) prescribing for the interval of up to 45 days after an acute painful event; and

166.9 (iii) prescribing for chronic pain, which for purposes of this program means pain lasting
166.10 longer than 45 days after an acute painful event;

166.11 (2) developing sentinel measures;

166.12 (3) developing educational resources for opioid prescribers about communicating with
166.13 patients about pain management and the use of opioids to treat pain;

166.14 (4) developing opioid quality improvement standard thresholds and opioid ~~disenrollment~~
166.15 standards for opioid prescribers and provider groups~~. In developing opioid disenrollment~~
166.16 ~~standards, the standards may be described in terms of the length of time in which prescribing~~
166.17 ~~practices fall outside community standards and the nature and amount of opioid prescribing~~
166.18 ~~that fall outside community standards~~; and

166.19 (5) addressing other program issues as determined by the commissioners.

166.20 (b) The opioid prescribing protocols shall not apply to opioids prescribed for patients
166.21 who are experiencing pain caused by a malignant condition or who are receiving hospice
166.22 care <u>or palliative care</u>, or to opioids prescribed for substance use disorder treatment with
166.23 medications for opioid use disorder.

166.24 (c) All opioid prescribers who prescribe opioids to Minnesota health care program
166.25 enrollees must participate in the program in accordance with subdivision 5. Any other
166.26 prescriber who prescribes opioids may comply with the components of this program described
166.27 in paragraph (a) on a voluntary basis.

166.28 Sec. 4. Minnesota Statutes 2022, section 256B.0638, subdivision 5, is amended to read:

166.29 Subd. 5. **Program implementation.** (a) The commissioner shall implement the ~~programs~~
166.30 ~~within the Minnesota health care~~ <u>quality improvement</u> program to improve the health of
166.31 and quality of care provided to Minnesota health care program enrollees. <u>The program must</u>

167.1 be designed to support patient-centered care consistent with community standards of care.
167.2 The program must discourage unsafe tapering practices and patient abandonment by
167.3 providers. The commissioner shall annually collect and report to provider groups the sentinel
167.4 measures of data showing individual opioid prescribers' opioid prescribing patterns compared
167.5 to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted,
167.6 or employed opioid prescribers.

167.7 (b) The commissioner shall notify an opioid prescriber and all provider groups with
167.8 which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing
167.9 pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber
167.10 and any provider group that receives a notice under this paragraph shall submit to the
167.11 commissioner a quality improvement plan for review and approval by the commissioner
167.12 with the goal of bringing the opioid prescriber's prescribing practices into alignment with
167.13 community standards. A quality improvement plan must include:

167.14 (1) components of the program described in subdivision 4, paragraph (a);

167.15 (2) internal practice-based measures to review the prescribing practice of the opioid
167.16 prescriber and, where appropriate, any other opioid prescribers employed by or affiliated
167.17 with any of the provider groups with which the opioid prescriber is employed or affiliated;
167.18 and

167.19 (3) ~~appropriate use of the prescription monitoring program under section 152.126~~
167.20 demonstration of patient-centered care consistent with community standards of care.

167.21 (c) If, after a year from the commissioner's notice under paragraph (b), the opioid
167.22 prescriber's prescribing practices for treatment of acute or postacute pain do not improve
167.23 so that they are consistent with community standards, the commissioner ~~shall~~ may take one
167.24 or more of the following steps:

167.25 (1) require the prescriber, the provider group, or both, to monitor prescribing practices
167.26 more frequently than annually;

167.27 (2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel
167.28 measures; or

167.29 (3) require the opioid prescriber to participate in additional quality improvement efforts~~,~~
167.30 ~~including but not limited to mandatory use of the prescription monitoring program established~~
167.31 ~~under section 152.126~~.

167.32 (d) Prescribers treating patients who are on chronic, high doses of opioids must meet
167.33 community standards of care, including performing regular assessments and addressing

168.1 unwarranted risks of opioid prescribing, but are not required to show measurable changes
168.2 in chronic pain prescribing thresholds within a certain period.

168.3 (e) The commissioner shall dismiss a prescriber from participating in the opioid
168.4 prescribing quality improvement program when the prescriber demonstrates that the
168.5 prescriber's practices are patient-centered and reflect community standards for safe and
168.6 compassionate treatment of patients experiencing pain.

168.7 ~~(d)~~ (f) The commissioner ~~shall terminate from Minnesota health care programs~~ may
168.8 investigate for possible sanctions under section 256B.064 all opioid prescribers and provider
168.9 groups whose prescribing practices fall within the applicable opioid ~~disenrollment~~ sanction
168.10 standards.

168.11 (e) No physician, advanced practice registered nurse, or physician assistant, acting in
168.12 good faith based on the needs of the patient, may be disenrolled by the commissioner of
168.13 human services solely for prescribing a dosage that equates to an upward deviation from
168.14 morphine milligram equivalent dosage recommendations specified in state or federal opioid
168.15 prescribing guidelines or policies, or quality improvement thresholds established under this
168.16 section.

168.17 Sec. 5. Minnesota Statutes 2022, section 256B.0638, is amended by adding a subdivision
168.18 to read:

168.19 Subd. 8. **Sanction standards.** (a) Providers enrolled in medical assistance under section
168.20 256B.04, subdivision 21, providing services to persons enrolled in medical assistance or
168.21 MinnesotaCare may be subject to sanctions under section 256B.064 for the following
168.22 practices:

168.23 (1) discontinuing, either abruptly or in the form of a rapid taper, chronic opioid analgesic
168.24 therapy from daily doses greater or equal to 50 morphine milligram equivalents a day without
168.25 providing patient support. Discontinuing without providing patient support includes failing
168.26 to:

168.27 (i) document and communicate to the patient a clinical rationale for the opioid
168.28 discontinuation and for the taper plan or speed;

168.29 (ii) ascertain pregnancy status in women of childbearing age prior to beginning the
168.30 discontinuation;

168.31 (iii) provide adequate follow-up care to the patient during the opioid discontinuation;

168.32 (iv) document a safety and pain management plan prior to or during the discontinuation;

169.1 (v) respond promptly and appropriately to patient-expressed psychological distress,
169.2 including but not limited to suicidal ideation;

169.3 (vi) assess the patient for active, moderate to severe substance use disorder, including
169.4 but not limited to opioid use disorder, and refer or treat the patient as appropriate; or

169.5 (vii) document and address patient harm when it arises. This includes but is not limited
169.6 to known harms reported by the patient, harms evident in a clinical evaluation, or harms
169.7 that should have been known through adequate chart review;

169.8 (2) continuing chronic opioid analgesic therapy without a safety plan when specific red
169.9 flags for opioid use disorder are present. Failure to develop a safety plan includes but is not
169.10 limited to failing to:

169.11 (i) document and address risks related to the condition or patterns of behavior and the
169.12 potential health consequences that an undiagnosed or untreated opioid use disorder poses
169.13 to the patient;

169.14 (ii) pursue a diagnosis when an opioid use disorder is suspected;

169.15 (iii) include a clear explanation of the safety plan in the patient's health record and
169.16 evidence that the plan was communicated to the patient; and

169.17 (iv) document the clinical rationale for continuing therapy despite the presence of red
169.18 flags. Red flags for opioid use disorder that require provider response under this section
169.19 include:

169.20 (A) a history of overdose known to the prescriber or evident from the patient's medical
169.21 record in the past 12 months;

169.22 (B) a history of an episode of opioid withdrawal that is not otherwise explained and is
169.23 known to the prescriber or evident from the patient's medical record in the past 12 months;

169.24 (C) a known history of opioid use disorder. If the opioid use disorder is moderate to
169.25 severe and the diagnosis was made within the past 12 months, a higher degree of
169.26 consideration must be included in the safety plan;

169.27 (D) a history of opioid use resulting in neglect of other aspects of the patient's health
169.28 that may result in serious harm known to the prescriber or evident from the patient's medical
169.29 record in the past 12 months;

169.30 (E) an active alcohol use disorder. If the alcohol use disorder is moderate to severe, a
169.31 higher degree of consideration must be included in the safety plan;

170.1 (F) a close personal contact of the patient expressing credible concern about the practice
170.2 of use or safety of the patient indicating imminent harm to the patient or an opioid use
170.3 disorder diagnosis;

170.4 (G) a pattern of deceptive actions by the patient to obtain opioid prescriptions. Deceptive
170.5 actions may include but are not limited to forging prescriptions, tampering with prescriptions,
170.6 and falsely reporting to medical staff with the intent of obtaining or protecting an opioid
170.7 supply;

170.8 (H) a pattern of behavior by the patient that is indicative of loss of control or continued
170.9 opioid use despite harm. Behaviors indicating a loss of control or continued use include but
170.10 are not limited to a pattern of recurrent lost prescriptions, patient requests to increase dosage
170.11 that are not supported by clinical reasoning, and a pattern of early refill requests without a
170.12 change in clinical condition;

170.13 (3) prescribing greater than 400 morphine milligram equivalents per day without
170.14 assessment of the risk for opioid-induced respiratory depression, without responding to
170.15 evidence of opioid-related harm, and without mitigating the risk of opioid-induced respiratory
170.16 depression. Failure to address risk of opioid-related harm includes but is not limited to
170.17 failure to:

170.18 (i) assess and document the diagnosis or diagnoses to be managed with chronic opioid
170.19 analgesic therapy;

170.20 (ii) assess and document comorbid health conditions that may impact the safety of opioid
170.21 therapy;

170.22 (iii) screen and document a patient-specific, opioid-related risk benefit analysis;

170.23 (iv) respond to evidence of harm within the patient's medical record. Evidence of harm
170.24 includes but is not limited to opioid-related falls, nonfatal overdoses, and appearing sedated
170.25 or with respiratory compromise at clinical visits;

170.26 (v) document clinical decision making if dosage is increased;

170.27 (vi) document discussion of an opioid taper with the patient on at least an annual basis;
170.28 and

170.29 (vii) evaluate the patient in person at least every three months or failing to assess for
170.30 diversion;

170.31 (4) continuing chronic opioid analgesic therapy at the same dosage without a safety plan
170.32 when risk factors for serious opioid-induced respiratory depression are present. Failing to

171.1 develop a safety plan includes failing to document the risk factor as a risk of opioid-induced
171.2 respiratory depression in the patient's health record and failing to document a clear safety
171.3 plan in the patient's health record that addresses actions to reduce the risk for serious
171.4 opioid-induced respiratory depression. Risk factors for serious opioid-induced respiratory
171.5 depression include but are not limited to:

171.6 (i) an active or symptomatic and untreated substance use disorder;

171.7 (ii) a serious mental health condition, including symptomatic, untreated mania;
171.8 symptomatic, untreated psychosis; and symptomatic, untreated suicidality;

171.9 (iii) an emergency department visit with a life-threatening opioid complication in the
171.10 last 12 months;

171.11 (iv) a pattern of inconsistent urine toxicology results, excluding the presence of
171.12 cannabinoids; however, addressing an inconsistent urine toxicology result must not result
171.13 in the overall worsening clinical status of the patient;

171.14 (v) the concurrent prescribing of long-term benzodiazepine therapy to an individual on
171.15 chronic opioid analgesic therapy;

171.16 (vi) a pulmonary disease with respiratory failure or hypoventilation; and

171.17 (vii) a failure to select and dose opioids safely for patients with known renal insufficiency;
171.18 and

171.19 (5) failing to participate in the Opioid Prescribing Improvement program for two
171.20 consecutive years.

171.21 Sec. 6. Minnesota Statutes 2022, section 256B.064, subdivision 1a, is amended to read:

171.22 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose
171.23 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse
171.24 in connection with the provision of medical care to recipients of public assistance; (2) a
171.25 pattern of presentment of false or duplicate claims or claims for services not medically
171.26 necessary; (3) a pattern of making false statements of material facts for the purpose of
171.27 obtaining greater compensation than that to which the vendor is legally entitled; (4)
171.28 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access
171.29 during regular business hours to examine all records necessary to disclose the extent of
171.30 services provided to program recipients and appropriateness of claims for payment; (6)
171.31 failure to repay an overpayment or a fine finally established under this section; (7) failure
171.32 to correct errors in the maintenance of health service or financial records for which a fine

172.1 was imposed or after issuance of a warning by the commissioner; and (8) any reason for
172.2 which a vendor could be excluded from participation in the Medicare program under section
172.3 1128, 1128A, or 1866(b)(2) of the Social Security Act.

172.4 (b) The commissioner may impose sanctions against a pharmacy provider for failure to
172.5 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph
172.6 (h).

172.7 (c) The commissioner may impose sanctions against a vendor for violations of the
172.8 sanction standards defined by the Opioid Prescribing Work Group for opioid prescribing
172.9 practices that fall outside community standard thresholds for prescribing.

172.10 **EFFECTIVE DATE.** This section is effective July 1, 2023.

172.11 **ARTICLE 7**

172.12 **DEPARTMENT OF DIRECT CARE AND TREATMENT**

172.13 Section 1. Minnesota Statutes 2022, section 246.54, subdivision 1a, is amended to read:

172.14 Subd. 1a. **Anoka-Metro Regional Treatment Center.** (a) A county's payment of the
172.15 cost of care provided at Anoka-Metro Regional Treatment Center shall be according to the
172.16 following schedule:

172.17 (1) zero percent for the first 30 days;

172.18 (2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate
172.19 for the client; and

172.20 (3) 100 percent for each day during the stay, including the day of admission, when the
172.21 facility determines that it is clinically appropriate for the client to be discharged. The county
172.22 is responsible for 50 percent of the cost of care under this clause for a person committed as
172.23 a person who has a mental illness and is dangerous to the public under section 253B.18 and
172.24 who is awaiting transfer to another state-operated facility or program.

172.25 Notwithstanding any law to the contrary, the client is not responsible for payment of the
172.26 cost of care under this subdivision.

172.27 (b) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent
172.28 of the cost of care for days over 31 for clients who meet the criteria in paragraph (a), clause
172.29 (2), the county shall be responsible for paying the state only the remaining amount. The
172.30 county shall not be entitled to reimbursement from the client, the client's estate, or from the
172.31 client's relatives, except as provided in section 246.53.

173.1 Sec. 2. Minnesota Statutes 2022, section 246.54, subdivision 1b, is amended to read:

173.2 Subd. 1b. **Community behavioral health hospitals.** (a) A county's payment of the cost
173.3 of care provided at state-operated community-based behavioral health hospitals for adults
173.4 and children shall be according to the following schedule:

173.5 (1) 100 percent for each day during the stay, including the day of admission, when the
173.6 facility determines that it is clinically appropriate for the client to be discharged except as
173.7 provided under paragraph (b); and

173.8 (2) the county shall not be entitled to reimbursement from the client, the client's estate,
173.9 or from the client's relatives, except as provided in section 246.53.

173.10 (b) The county is responsible for 50 percent of the cost of care under paragraph (a),
173.11 clause (1), for a person committed as a person who has a mental illness and is dangerous
173.12 to the public under section 253B.18 and who is awaiting transfer to another state-operated
173.13 facility or program.

173.14 (c) Notwithstanding any law to the contrary, the client is not responsible for payment
173.15 of the cost of care under this subdivision."

173.16 Amend the title accordingly