SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 4399

(SENATE AUTHORS: HOFFMAN)

DATE	D-PG	OFFICIAL STATUS
02/29/2024	11848	Introduction and first reading
		Referred to Human Services
03/25/2024	12583a	Comm report: To pass as amended
	12882	Second reading
04/04/2024	13384a	Special Order: Amended
	13392	Third reading Passed

A bill for an act

relating to human services; modifying and establishing laws regarding disability services, aging services, and substance use disorder treatment services; modifying assisted living facility licensing standards; modernizing language in Deaf and Hard-of-Hearing Services Act; expanding application of bloodborne pathogen testing to nonsecure direct care and treatment programming; making technical corrections and repealing obsolete language; limiting rent increases in certain low-income rental projects receiving low-income housing tax credits; amending Minnesota Statutes 2022, sections 144A.20, subdivision 4; 144G.30, subdivision 5; 144G.45, subdivision 3; 148F.025, subdivision 2; 245A.11, subdivision 2; 245D.071, subdivisions 3, 4; 245D.081, subdivisions 2, 3; 245D.09, subdivision 3; 245D.091, subdivisions 3, 4; 245D.10, subdivision 1; 245F.02, subdivisions 17, 21; 245F.08, subdivision 3; 245F.15, subdivision 7; 245G.031, subdivision 2; 245G.04, by adding a subdivision; 245G.22, subdivision 6; 246.71, subdivisions 3, 4, 5; 246.711; 246.712, subdivisions 1, 2; 246.713; 246.714; 246.715, subdivisions 1, 2, 3; 246.716, subdivisions 1, 2, as amended; 246.717; 246.721, as amended; 246.722; 254A.03, subdivision 1; 256.975, subdivision 7e; 256B.0659, subdivision 17a; 256B.0759, subdivision 4; 256B.0911, subdivision 24; 256B.092, by adding a subdivision; 256B.49, by adding a subdivision; 256B.4905, subdivision 12; 256B.69, subdivision 5k, by adding a subdivision; 256B.85, subdivisions 2, 6, 6a, 7a, 11, 17, 20, by adding a subdivision; 256C.21; 256C.23, subdivisions 1a, 2, 2a, 2b, 2c, 6, 7, by adding a subdivision; 256C.233, subdivisions 1, 2; 256C.24, subdivisions 1, 2, 3; 256C.26; 256C.261; 256C.28, subdivision 1; 256R.08, subdivision 1, by adding a subdivision; 256S.205, subdivision 5, by adding a subdivision; 402A.16, subdivision 2; Minnesota Statutes 2023 Supplement, sections 245G.05, subdivision 3; 245G.09, subdivision 3; 245G.11, subdivision 10; 245G.22, subdivisions 2, 17; 254A.19, subdivision 3; 254B.04, subdivision 6, by adding a subdivision; 254B.05, subdivisions 1, 5; 254B.181, subdivision 1; 254B.19, subdivision 1; 256B.057, subdivision 9; 256B.0659, subdivision 24; 256B.0759, subdivision 2; 256B.4914, subdivisions 4, 10, 10a; 256B.85, subdivision 13a; Laws 2021, First Special Session chapter 7, article 11, section 38, as amended; article 13, section 75; Laws 2023, chapter 61, article 8, section 13, subdivision 2; repealing Minnesota Statutes 2022, sections 245G.011, subdivision 5; 245G.22, subdivisions 4, 7; 252.34; 256.01, subdivision 39; 256.975, subdivisions 7f, 7g; 256R.18.

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

ARTICLE 1
DISABILITY SERVICES

Section 1. Minnesota Statutes 2022, section 144G.45, subdivision 3, is amended to read:

Subd. 3. **Local laws apply.** Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.

Sec. 2. Minnesota Statutes 2022, section 245A.11, subdivision 2, is amended to read:

Subd. 2. **Permitted single-family residential use.** (a) Residential programs with a licensed capacity of six or fewer persons shall be considered a permitted single-family residential use of property for the purposes of zoning and other land use regulations, except that a residential program whose primary purpose is to treat juveniles who have violated criminal statutes relating to sex offenses or have been adjudicated delinquent on the basis of conduct in violation of criminal statutes relating to sex offenses shall not be considered a permitted use. This exception shall not apply to residential programs licensed before July 1, 1995. Programs otherwise allowed under this subdivision shall not be prohibited by operation of restrictive covenants or similar restrictions, regardless of when entered into, which cannot be met because of the nature of the licensed program, including provisions which require the home's occupants be related, and that the home must be occupied by the owner, or similar provisions.

~~(b) Unless otherwise provided in any town, municipal, or county zoning regulation, licensed residential services provided to more than four persons with developmental disabilities in a supervised living facility, including intermediate care facilities for persons with developmental disabilities, with a licensed capacity of seven to eight persons shall be considered a permitted single-family residential use of property for the purposes of zoning and other land use regulations. A town, municipal, or county zoning authority may require a conditional use or special use permit to assure proper maintenance and operation of the residential program. Conditions imposed on the residential program must not be more restrictive than those imposed on other conditional uses or special uses of residential property in the same zones, unless the additional conditions are necessary to protect the health and safety of the persons being served by the program. This paragraph expires July 1, 2023.~~

(b) A residential program as defined in section 245D.02, subdivision 4a, with a licensed capacity of six or fewer persons that is actively serving residents for which it is licensed is exempt from rental licensing regulations imposed by any town, municipality, or county.

Sec. 3. Minnesota Statutes 2022, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary support plan addendum based on the support plan.

(b) Within the scope of services, the license holder must, at a minimum, complete assessments in the following areas before ~~the 45-day planning meeting~~ providing 45 days of service or within 60 calendar days of service initiation, whichever is shorter:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and welfare of the person or others.

Assessments must produce information about the person that describes the person's overall strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) Before providing 45 days of service or within 60 calendar days of service initiation, whichever is shorter, the license holder must ~~meet~~ hold an initial planning meeting with the person, the person's legal representative, the case manager, other members of the support team or expanded support team, and other people as identified by the person or the person's legal representative to determine the following based on information obtained from the

assessments identified in paragraph (b), the person's identified needs in the support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;

(4) whether the current service setting is the most integrated setting available and appropriate for the person;

(5) opportunities to develop and maintain essential and life-enriching skills, abilities, strengths, interests, and preferences;

(6) opportunities for community access, participation, and inclusion in preferred community activities;

(7) opportunities to develop and strengthen personal relationships with other persons of the person's choice in the community;

(8) opportunities to seek competitive employment and work at competitively paying jobs in the community; and

(9) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

(d) A discussion of how technology might be used to meet the person's desired outcomes must be included in the ~~45-day~~ initial planning meeting. The support plan or support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made. Nothing in this paragraph requires that the support plan include the use of technology for the provision of services.

Sec. 4. Minnesota Statutes 2022, section 245D.071, subdivision 4, is amended to read:

Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the ~~45-day~~ initial planning meeting, the license holder must develop a service plan that documents the service outcomes and supports based on the assessments completed under subdivision 3

and the requirements in section 245D.07, subdivision 1a. The outcomes and supports must be included in the support plan addendum.

(b) The license holder must document the supports and methods to be implemented to support the person and accomplish outcomes related to acquiring, retaining, or improving skills and physical, mental, and emotional health and well-being. The documentation must include:

(1) the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:

(i) any changes or modifications to the physical and social environments necessary when the service supports are provided;

(ii) any equipment and materials required; and

(iii) techniques that are consistent with the person's communication mode and learning style;

(2) the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;

(3) the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and

(4) the names of the staff or position responsible for implementing the supports and methods.

(c) Within 20 working days of the ~~45-day~~ initial planning meeting, the license holder must submit to and obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and support plan addendum. If, within ten working days of the submission of the assessment or support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the assessment and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the assessment and support plan addendum become effective and remain in effect until the legal representative or case manager submits a written request to revise the assessment or support plan addendum.

Sec. 5. Minnesota Statutes 2022, section 245D.081, subdivision 2, is amended to read:

Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery and evaluation of services provided by the license holder must be coordinated by a designated staff person. Except as provided in clause (3), the designated coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities assigned in the person's support plan and the support plan addendum;

(2) taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

(3) instruction and assistance to direct support staff implementing the support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency. The designated coordinator may delegate the direct observation and competency assessment of the service delivery activities of direct support staff to an individual whom the designated coordinator has previously deemed competent in those activities; and

(4) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.

(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education, training, and work experience relevant to the primary disability of persons served by the license holder and the individual persons for whom the designated coordinator is responsible. The designated coordinator must have the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

(1) a baccalaureate degree ~~in a field related to human services,~~ and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(2) an associate degree ~~in a field related to human services,~~ and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(3) a diploma ~~in a field related to human services~~ from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or

(4) a minimum of 50 hours of education and training related to human services and disabilities; and

(5) four years of ~~full-time work~~ experience providing direct care services to persons with disabilities or persons age 65 and older ~~under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3)~~.

Sec. 6. Minnesota Statutes 2022, section 245D.081, subdivision 3, is amended to read:

Subd. 3. **Program management and oversight.** (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph (g);

(2) ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

(3) ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and conditions of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience ~~in a program providing direct support services to persons with disabilities or persons age 65 and older~~.

Sec. 7. Minnesota Statutes 2022, section 245D.09, subdivision 3, is amended to read:

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education relevant to the primary disability of the person and to meet the person's needs and additional requirements as written in the support plan or support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and to the primary disability of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the support plan or support plan addendum;

(2) demonstrated competency in the orientation and training areas required under this chapter, and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing or observed skill assessment conducted by the trainer or instructor or by an individual who has been previously deemed competent by the trainer or instructor in the area being assessed; and

(3) except for a license holder who is the sole direct support staff, periodic performance evaluations completed by the license holder of the direct support staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties ~~or administer medication~~.

Sec. 8. Minnesota Statutes 2022, section 245D.091, subdivision 3, is amended to read:

Subd. 3. **Positive support analyst qualifications.** (a) A positive support analyst providing positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in one of the following areas as required under the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans or successor plans:

(1) have obtained a baccalaureate degree, master's degree, or PhD in either a social services discipline or nursing;

(2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision 17; or

(3) be a board-certified behavior analyst or board-certified assistant behavior analyst by the Behavior Analyst Certification Board, Incorporated.

(b) In addition, a positive support analyst must:

(1) have four years of supervised experience ~~conducting functional behavior assessments and designing, implementing, and evaluating effectiveness of positive practices behavior support strategies for people~~ working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;

(2) have received training prior to hire or within 90 calendar days of hire that includes:

(i) ten hours of instruction in functional assessment and functional analysis;

(ii) 20 hours of instruction in the understanding of the function of behavior;

(iii) ten hours of instruction on design of positive practices behavior support strategies;

(iv) 20 hours of instruction preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice strategies, summarizing and reporting program evaluation data, analyzing program evaluation data to identify design flaws in behavioral interventions or failures in implementation fidelity, and recommending enhancements based on evaluation data; and

(v) eight hours of instruction on principles of person-centered thinking;

(3) be determined by a positive support professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives positive support; and

(4) be under the direct supervision of a positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraph (b).

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

Sec. 9. Minnesota Statutes 2022, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **Positive support specialist qualifications.** (a) A positive support specialist providing positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in one of the following areas as required under the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans or successor plans:

(1) have an associate's degree in either a social services discipline or nursing; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received training prior to hire or within 90 calendar days of hire that includes:

(i) a minimum of four hours of training in functional assessment;

(ii) 20 hours of instruction in the understanding of the function of behavior;

(iii) ten hours of instruction on design of positive practices behavioral support strategies; and

(iv) eight hours of instruction on principles of person-centered thinking;

(2) be determined by a positive support professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior reduction approved intervention to the person who receives positive support; and

(3) be under the direct supervision of a positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

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

Sec. 10. Minnesota Statutes 2022, section 245D.10, subdivision 1, is amended to read:

Subdivision 1. **Policy and procedure requirements.** A license holder providing either basic or intensive supports and services must establish, enforce, and maintain policies and procedures as required in this chapter, chapter 245A, and other applicable state and federal laws and regulations governing the provision of home and community-based services licensed according to this chapter. A license holder must use forms provided by the commissioner to report service suspensions and service terminations under subdivisions 3 and 3a.

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

Sec. 11. Minnesota Statutes 2023 Supplement, 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; and

(2) 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, be receiving an unemployment insurance benefit under chapter 268 that the person began receiving while eligible under this subdivision, or be receiving family and medical leave benefits under chapter 268B that the person began receiving while eligible under this subdivision. 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 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 would otherwise be ineligible and be disenrolled due to one of the following circumstances may retain eligibility for up to four consecutive months after a month of job loss if the person:

(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.

To receive a four-month extension of continued eligibility under this paragraph, enrollees must verify the medical condition or provide notification of job loss, continue to meet all other eligibility requirements, and continue to pay all calculated premium costs.

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

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

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

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

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

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

(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.

(f) Any required premium shall be determined at application and redetermined at the enrollee's ~~six-month~~ 12-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ~~ten~~ 30 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~~ 12-month review.

(g) 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.

(h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

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

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

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

Subd. 17a. **Enhanced rate.** (a) An enhanced rate of 107.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for ten or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d).

(b) A personal care assistance provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the personal care assistants, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums. The agency must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

(c) Any change in the eligibility criteria for the enhanced rate for personal care assistance services as described in this subdivision and referenced in subdivision 11, paragraph (d), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

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

Sec. 13. Minnesota Statutes 2023 Supplement, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

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

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

(16) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages ~~and benefits~~ and any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums of the PCAs whose services meet the requirements under subdivision 11, paragraph (d); and

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

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

Sec. 16. Minnesota Statutes 2022, section 256B.0911, subdivision 24, is amended to read:

Subd. 24. **Remote reassessments.** (a) Assessments performed according to subdivisions 17 to 20 and 23 must be in person unless the assessment is a reassessment meeting the requirements of this subdivision. Remote reassessments conducted by interactive video or telephone may substitute for in-person reassessments.

(b) For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for two consecutive reassessments if followed by an in-person reassessment.

(c) For services provided by alternative care under section 256B.0913, essential community supports under section 256B.0922, and the elderly waiver under chapter 256S, remote reassessments may be substituted for one reassessment if followed by an in-person reassessment.

(d) For personal care assistance provided under section 256B.0659 and community first services and supports provided under section 256B.85, remote reassessments may be substituted for two consecutive reassessments if followed by an in-person reassessment.

~~(d)~~ (e) A remote reassessment is permitted only if the lead agency provides informed choice and the person being reassessed or the person's legal representative provides informed consent for a remote assessment. Lead agencies must document that informed choice was offered.

~~(e)~~ (f) The person being reassessed, or the person's legal representative, may refuse a remote reassessment at any time.

~~(f)~~ (g) During a remote reassessment, if the certified assessor determines an in-person reassessment is necessary in order to complete the assessment, the lead agency shall schedule an in-person reassessment.

~~(g)~~ (h) All other requirements of an in-person reassessment apply to a remote reassessment, including updates to a person's support plan.

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

Sec. 18. Minnesota Statutes 2022, section 256B.092, is amended by adding a subdivision to read:

Subd. 3a. **Authorization of technology services.** (a) Lead agencies must not implement additional requirements, in addition to those required by the commissioner, that could result in the delay of approval or implementation of technology.

(b) For individuals receiving waiver services under this section, approval or denial of technology must occur within 30 business days of the receipt of the initial request. If denied, the lead agency must submit a notice of action form clearly stating the reason for the denial, including information describing why the technology is not appropriate to meet the individual's assessed need.

Sec. 19. Minnesota Statutes 2022, section 256B.49, is amended by adding a subdivision to read:

Subd. 16b. **Authorization of technology services.** (a) Lead agencies must not implement additional requirements, in addition to those required by the commissioner, that could result in the delay of approval or implementation of technology.

(b) For individuals receiving waiver services under this section, approval or denial of technology must occur within 30 business days of the receipt of the initial request. If denied, the lead agency must submit a notice of action form clearly stating the reason for the denial,

including information describing why the technology is not appropriate to meet the individual's assessed need.

Sec. 20. Minnesota Statutes 2022, section 256B.4905, subdivision 12, is amended to read:

Subd. 12. **Informed choice ~~in~~ and technology prioritization in implementation for disability waiver services.** The commissioner of human services shall ensure that:

(1) disability waivers under sections 256B.092 and 256B.49 support the presumption that all adults who have disabilities and children who have disabilities may use assistive technology, remote supports, or both to enhance the adult's or child's independence and quality of life; and

(2) each individual accessing waiver services is offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose assistive technology, remote support, or both prior to the commissioner offering or reauthorizing services that utilize direct support staff to ensure equitable access.

Sec. 21. Minnesota Statutes 2023 Supplement, section 256B.4914, subdivision 4, is amended to read:

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

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

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

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

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

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

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

(9) service hours provided through monitoring technology.

(d) Updates to individual data must include:

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

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

(e) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6 to 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, 2025.

Sec. 22. Minnesota Statutes 2022, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section and section 256B.851, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means:

(1) dressing, including assistance with choosing, applying, and changing clothing and applying special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail care, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and applying orthotics required for eating~~, transfers,~~ or feeding;

(5) transfers, including assistance with transferring the participant from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant;

(7) positioning, including assistance with positioning or turning a participant for necessary care and comfort; and

(8) toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, advanced practice registered nurse, or physician's assistant and is specified in an assessment summary, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse, or physician's assistant and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the support plan identified in sections 256B.092, subdivision 1b, and 256S.10.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child must not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092,

subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community, including traveling to medical appointments. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the individual CFSS service delivery plan.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 10.

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression toward self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker must not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's

hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one.

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into a written agreement to receive services at the same time, in the same setting, and through the same agency-provider or FMS provider.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

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

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 23. Minnesota Statutes 2022, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the support plan identified in sections 256B.092, subdivision 1b, and 256S.10. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS provider prior to starting services and at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the consultation services provider, agency-provider, or FMS provider selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the methods and supports used to address the needs as identified through an assessment of functional needs;

(5) include the participant's identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, including the costs of the services and supports, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan;

(13) prevent the provision of unnecessary or inappropriate care;

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development provided according to subdivision 18a detailing what service components will be used, when the service components will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The CFSS service delivery plan must describe the units or dollar amount available to the participant. The total units of agency-provider services or the service budget amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service agreement. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount, determined according to subdivision 8, unless a change in condition is assessed and authorized by the certified assessor and documented in the support plan and CFSS service delivery plan.

(e) In assisting with the development or modification of the CFSS service delivery plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS provider on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager or care coordinator.

(f) The CFSS service delivery plan must be approved by the ~~consultation services provider~~ lead agency for participants without a case manager or care coordinator who is responsible

for authorizing services. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 24. Minnesota Statutes 2022, section 256B.85, subdivision 6a, is amended to read:

Subd. 6a. **Person-centered planning process.** The person-centered planning process must:

(1) include people chosen by the participant;

(2) provide necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

(3) be timely and occur at times and locations convenient to the participant;

(4) reflect cultural considerations of the participant;

(5) include within the process strategies for solving conflict or disagreement, including clear conflict-of-interest guidelines as identified in Code of Federal Regulations, title 42, section ~~441.500~~ 441.540, for all planning;

(6) provide the participant choices of the services and supports the participant receives and the staff providing those services and supports;

(7) include a method for the participant to request updates to the plan; and

(8) record the alternative home and community-based settings that were considered by the participant.

Sec. 27. Minnesota Statutes 2022, section 256B.85, subdivision 7a, is amended to read:

Subd. 7a. **Enhanced rate.** (a) An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e).

(b) An agency provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the support workers, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums. The agency provider must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life

insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

(c) Any change in the eligibility criteria for the enhanced rate for CFSS as described in this subdivision and referenced in subdivision 16, paragraph (e), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

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

Sec. 25. Minnesota Statutes 2022, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an agency-provider that meets the criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's CFSS service delivery plan. The agency must make a reasonable effort to fulfill the participant's request for the participant's preferred support worker.

(c) A participant may use authorized units of CFSS services as needed within a service agreement that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's CFSS service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by participants who are restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the CFSS service delivery plan and detailed budget for expenditures that must be approved by the ~~consultation services provider~~ lead agency, case manager, or care coordinator; and

(2) use the FMS provider for the billing and payment of such goods.

(h) The agency provider is responsible for ensuring that any worker driving a participant under subdivision 2, paragraph (o), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

Sec. 26. Minnesota Statutes 2023 Supplement, section 256B.85, subdivision 13a, is amended to read:

Subd. 13a. **Financial management services.** (a) Services provided by an FMS provider include but are not limited to: filing and payment of federal and state payroll taxes and premiums on behalf of the participant; initiating and complying with background study requirements under chapter 245C and maintaining documentation of background study requests and results; billing for approved CFSS services with authorized funds; monitoring expenditures; accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for liability, workers' compensation, family and medical benefit insurance, and unemployment coverage; and providing participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

(b) Agency-provider services shall not be provided by the FMS provider.

(c) The FMS provider shall provide service functions as determined by the commissioner for budget model participants that include but are not limited to:

(1) assistance with the development of the detailed budget for expenditures portion of the CFSS service delivery plan as requested by the consultation services provider or participant;

(2) data recording and reporting of participant spending;

(3) other duties established by the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing employer responsibilities regarding support workers. The support worker shall not be considered the employee of the FMS provider; and

(4) billing, payment, and accounting of approved expenditures for goods.

(d) The FMS provider shall obtain an assurance statement from the participant employer agreeing to follow state and federal regulations and CFSS policies regarding employment of support workers.

(e) The FMS provider shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

(2) provide the participant, consultation services provider, and case manager or care coordinator, if applicable, with a monthly written summary of the spending for services and supports that were billed against the spending budget;

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under chapter 268B and section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability for vendor fiscal/employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(4) have current and adequate liability insurance and bonding and sufficient cash flow as determined by the commissioner and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting;

(5) assume fiscal accountability for state funds designated for the program and be held liable for any overpayments or violations of applicable statutes or rules, including but not limited to the Minnesota False Claims Act, chapter 15C;

(6) maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the commissioner. Claims submitted by the FMS provider to the commissioner for payment must correspond with

services, amounts, and time periods as authorized in the participant's service budget and service plan and must contain specific identifying information as determined by the commissioner; and

(7) provide written notice to the participant or the participant's representative at least 30 calendar days before a proposed service termination becomes effective, except in cases where:

(i) the participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the FMS;

(ii) the participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other staff; or

(iii) an emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the plan cannot safely meet the participant's needs.

(f) The commissioner shall:

(1) establish rates and payment methodology for the FMS provider;

(2) identify a process to ensure quality and performance standards for the FMS provider and ensure statewide access to FMS providers; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS providers.

Sec. 27. Minnesota Statutes 2022, section 256B.85, subdivision 17, is amended to read:

Subd. 17. **Consultation services duties.** Consultation services is a required service that includes:

(1) entering into a written agreement with the participant, participant's representative, or legal representative that includes but is not limited to the details of services, service delivery methods, dates of services, and contact information;

(2) providing an initial and annual orientation to CFSS information and policies, including selecting a service model;

(3) assisting with accessing FMS providers or agency-providers;

(4) providing assistance with the development, implementation, management, documentation, and evaluation of the person-centered CFSS service delivery plan;

~~(5) approving the CFSS service delivery plan for a participant without a case manager or care coordinator who is responsible for authorizing services;~~

~~(6)~~ (5) maintaining documentation of the approved CFSS service delivery plan;

~~(7)~~ (6) distributing copies of the final CFSS service delivery plan to the participant and to the agency-provider or FMS provider, case manager or care coordinator, and other designated parties;

~~(8)~~ (7) assisting to fulfill responsibilities and requirements of CFSS, including modifying CFSS service delivery plans and changing service models;

~~(9)~~ (8) if requested, providing consultation on recruiting, selecting, training, managing, directing, supervising, and evaluating support workers;

~~(10)~~ (9) evaluating services upon receiving information from an FMS provider indicating spending or participant employer concerns;

~~(11)~~ (10) reviewing the use of and access to informal and community supports, goods, or resources;

~~(12)~~ (11) a semiannual review of services if the participant does not have a case manager or care coordinator and when the support worker is a paid parent of a minor participant or the participant's spouse;

~~(13)~~ (12) collecting and reporting of data as required by the department;

~~(14)~~ (13) providing the participant with a copy of the participant protections under subdivision 20 at the start of consultation services;

~~(15)~~ (14) providing assistance to resolve issues of noncompliance with the requirements of CFSS;

~~(16)~~ (15) providing recommendations to the commissioner for changes to services when support to participants to resolve issues of noncompliance have been unsuccessful; and

~~(17)~~ (16) other duties as assigned by the commissioner.

Sec. 28. Minnesota Statutes 2022, section 256B.85, is amended by adding a subdivision to read:

Subd. 18b. **Worker training and development services; remote visits.** (a) Except as provided in paragraph (b), the worker training and development services specified in

subdivision 18a, paragraph (c), clauses (3) and (4), may be provided to recipients with chronic health conditions or severely compromised immune systems via two-way interactive audio and visual telecommunications if, at the recipient's request, the recipient's primary health care provider:

(1) determines that remote worker training and development services are appropriate; and

(2) documents the determination under clause (1) in a statement of need or other document that is subsequently included in the recipient's CFSS service delivery plan.

(b) The worker training and development services specified in subdivision 18a, paragraph (c), clause (3), provided at the start of services or the start of employment of a new support worker must not be conducted via two-way interactive audio and visual telecommunications.

(c) A recipient may request to return to in-person worker training and development services at any time.

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

Sec. 29. Minnesota Statutes 2022, section 256B.85, subdivision 20, is amended to read:

Subd. 20. **Participant protections.** (a) All CFSS participants have the protections identified in this subdivision.

(b) Participants or participant's representatives must be provided with adequate information, counseling, training, and assistance, as needed, to ensure that the participant is able to choose and manage services, models, and budgets. This information must be provided by the consultation services provider at the time of the initial or annual orientation to CFSS, at the time of reassessment, or when requested by the participant or participant's representative. This information must explain:

(1) person-centered planning;

(2) the range and scope of participant choices, including the differences between the agency-provider model and the budget model, available CFSS providers, and other services available in the community to meet the participant's needs;

(3) the process for changing plans, services, and budgets;

(4) identifying and assessing appropriate services; and

(5) risks to and responsibilities of the participant under the budget model.

(c) The consultation services provider must ensure that the participant chooses freely between the agency-provider model and the budget model and among available agency-providers and that the participant may change agency-providers after services have begun.

(d) A participant who appeals a reduction in previously authorized CFSS services may continue previously authorized services pending an appeal in accordance with section 256.045.

(e) If the units of service or budget allocation for CFSS are reduced, denied, or terminated, the commissioner must provide notice of the reasons for the reduction in the participant's notice of denial, termination, or reduction.

(f) If all or part of a CFSS service delivery plan is denied approval by the ~~consultation services provider~~ lead agency, the ~~consultation services provider~~ lead agency must provide a notice that describes the basis of the denial.

Sec. 30. Laws 2021, First Special Session chapter 7, article 13, section 75, is amended to read:

Sec. 75. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; WAIVER REIMAGINE AND INFORMED CHOICE STAKEHOLDER CONSULTATION.**

Subdivision 1. **Stakeholder consultation; generally.** (a) The commissioner of human services must consult with and seek input and assistance from stakeholders concerning potential adjustments to the streamlined service menu from waiver reimagine phase I and to the existing rate exemption criteria and process.

(b) The commissioner of human services must consult with ~~and~~, seek input and assistance from, and collaborate with stakeholders concerning the development and implementation of waiver reimagine phase II, including criteria and a process for individualized budget exemptions, and how waiver reimagine phase II can support and expand informed choice and informed decision making, including integrated employment, independent living, and self-direction, consistent with Minnesota Statutes, section 256B.4905.

(c) The commissioner of human services must consult with, seek input and assistance from, and collaborate with stakeholders concerning the implementation and revisions of the MnCHOICES 2.0 assessment tool.

Subd. 2. **Public stakeholder engagement.** The commissioner must offer a public method to regularly receive input and concerns from people with disabilities and their families about waiver reimagine phase II. The commissioner shall provide ~~regular~~ quarterly public updates on policy development and on how recent stakeholder input ~~was used throughout the~~ is being incorporated into the current development and implementation of waiver reimagine phase II.

Subd. 3. **Waiver Reimagine Advisory Committee.** (a) The commissioner must convene, at regular intervals throughout the development and implementation of waiver reimagine phase II, a Waiver Reimagine Advisory Committee that consists of a group of diverse, representative stakeholders. The commissioner must solicit and endeavor to include racially, ethnically, and geographically diverse membership from each of the following groups:

(1) people with disabilities who use waiver services;

(2) family members of people who use waiver services;

(3) disability and behavioral health advocates;

(4) lead agency representatives; and

(5) waiver service providers.

(b) The assistant commissioner of aging and disability services must attend and participate in meetings of the Waiver Reimagine Advisory Committee.

(c) The Waiver Reimagine Advisory Committee must have the opportunity to ~~assist~~ collaborate in a meaningful way in developing and providing feedback on proposed plans for waiver reimagine components, including an individual budget methodology, criteria and a process for individualized budget exemptions, the consolidation of the four current home and community-based waiver service programs into two-waiver programs, the role of assessments and the MnCHOICES 2.0 assessment tool in determining service needs and individual budgets, and other aspects of waiver reimagine phase II.

~~(c)~~ (d) The Waiver Reimagine Advisory Committee must have an opportunity to assist in the development of and provide feedback on proposed adjustments and modifications to the streamlined menu of services and the existing rate exception criteria and process.

Subd. 4. **Required report.** Prior to seeking federal approval for any aspect of waiver reimagine phase II and in ~~consultation~~ collaboration with the Waiver Reimagine Advisory Committee, the commissioner must submit to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services a report on plans for waiver reimagine phase II. The report must also include any plans to

adjust or modify the streamlined menu of services ~~or~~, the existing rate exemption criteria or process, the proposed individual budget ranges, and the role of MnCHOICES 2.0 assessment tool in determining service needs and individual budget ranges.

Subd. 5. **Transition process.** (a) Prior to implementation of wavier reimagine phase II, the commissioner must establish a process to assist people who use waiver services and lead agencies transition to a two-waiver system with an individual budget methodology.

(b) The commissioner must ensure that the new waiver service menu and individual budgets allow people to live in their own home, family home, or any home and community-based setting of their choice. The commissioner must ensure, ~~within available resources and~~ subject to state and federal regulations and law, that waiver reimagine does not result in unintended service disruptions.

Subd. 6. **Online support planning tool.** The commissioner must develop an online support planning and tracking tool for people using disability waiver services that allows access to the total budget available to the person, the services for which they are eligible, and the services they have chosen and used. The commissioner must explore operability options that would facilitate real-time tracking of a person's remaining available budget throughout the service year. The online support planning tool must provide information in an accessible format to support the person's informed choice. The commissioner must seek input from people with disabilities about the online support planning tool prior to its implementation.

Subd. 7. **Curriculum and training.** The commissioner must develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to comply with informed decision making for people who used home and community-based disability waivers. Training and competency evaluations must be completed annually by all staff responsible for case management as described in Minnesota Statutes, sections 256B.092, subdivision 1a, paragraph (f), and 256B.49, subdivision 13, paragraph (e).

Sec. 32. **COMMUNITY ACCESS FOR DISABILITY INCLUSION WAIVER CUSTOMIZED LIVING SERVICES PROVIDERS LOCATED IN HENNEPIN COUNTY.**

The community access for disability inclusion (CADI) waiver customized living and 24-hour customized living size and age limitation does not apply to two housing settings located in the city of Minneapolis that are financed by low-income housing tax credits

created in calendar years 2005 and 2011 and in which 24-hour customized living services are provided to residents enrolled in the CADI waiver by Clare Housing.

ARTICLE 2
DEAF, DEAFBLIND, AND HARD-OF-HEARING SERVICES

Section 1. Minnesota Statutes 2022, section 256C.21, is amended to read:

256C.21 DEAF, DEAFBLIND, AND HARD-OF-HEARING SERVICES ACT; CITATION.

Sections 256C.21 to ~~256C.26~~ 256C.261 may be cited as the "Deaf, DeafBlind, and Hard-of-Hearing Services Act."

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

Sec. 2. Minnesota Statutes 2022, section 256C.23, subdivision 1a, is amended to read:

Subd. 1a. **Culturally affirmative.** "Culturally affirmative" describes services that are designed and delivered within the context of the culture, identity, language, communication, and life experiences of ~~a person~~ persons who ~~is~~ are deaf, ~~a person~~ persons who ~~is~~ are deafblind, and ~~a person~~ persons who ~~is~~ are hard-of-hearing.

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

Sec. 3. Minnesota Statutes 2022, section 256C.23, is amended by adding a subdivision to read:

Subd. 1b. **Linguistically affirmative.** "Linguistically affirmative" describes services that are designed and delivered within the context of the language and communication experiences of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing.

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

Sec. 4. Minnesota Statutes 2022, section 256C.23, subdivision 2, is amended to read:

Subd. 2. **Deaf.** "Deaf" means a hearing loss ~~of such severity that the individual must depend~~ where the person communicates primarily ~~on visual communication such as~~ through American Sign Language or ~~other~~ another signed language, ~~visual and manual means of communication such as~~ signing systems in English ~~or~~, Cued Speech, reading and writing, speech reading, ~~and gestures~~ or other visual communication.

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

Sec. 5. Minnesota Statutes 2022, section 256C.23, subdivision 2a, is amended to read:

Subd. 2a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss ~~resulting in a functional loss of hearing, but not to the extent that the individual must depend~~ where the person does not communicate primarily ~~upon~~ through visual communication.

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

Sec. 6. Minnesota Statutes 2022, section 256C.23, subdivision 2b, is amended to read:

Subd. 2b. **Deafblind.** "Deafblind" means any combination of vision and hearing loss ~~which interferes with acquiring information from the environment to the extent that compensatory~~ where the person uses visual, auditory, or tactile strategies and skills ~~are necessary~~ such as the use of a tactile form of a visual or spoken language to access ~~that~~ communication, information from the environment, or other information.

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

Sec. 7. Minnesota Statutes 2022, section 256C.23, subdivision 2c, is amended to read:

Subd. 2c. **Interpreting services.** "Interpreting services" means services that include:

(1) interpreting between a spoken language, such as English, and a visual language, such as American Sign Language or another signed language;

(2) interpreting between a spoken language and a visual representation of a spoken language, such as Cued Speech ~~and~~ or signing systems in English;

(3) interpreting within one language where the interpreter ~~uses natural gestures and~~ silently repeats the spoken message, replacing some words or phrases to ~~give higher visibility on the lips~~ make the message more readable;

(4) interpreting using low vision or tactile methods, signing systems, or signed languages for persons who ~~have a combined hearing and vision loss or~~ are deafblind; and

(5) interpreting from one communication mode or language into another communication mode or language that is linguistically and culturally appropriate for the participants in the communication exchange.

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

Sec. 8. Minnesota Statutes 2022, section 256C.23, subdivision 6, is amended to read:

Subd. 6. **Real-time captioning.** "Real-time captioning" means a method of captioning in which ~~a caption is~~ captions are simultaneously prepared and displayed or transmitted at the time of origination by specially trained real-time captioners.

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

Sec. 9. Minnesota Statutes 2022, section 256C.23, subdivision 7, is amended to read:

Subd. 7. **Family and community intervener.** "Family and community intervener" means a ~~paraprofessional,~~ person who is specifically trained in deafblindness~~, who~~ and works one-on-one with a child who is deafblind to provide critical ~~connections~~ access to language, communication, people, and the environment.

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

Sec. 10. Minnesota Statutes 2022, section 256C.233, subdivision 1, is amended to read:

Subdivision 1. **Deaf, DeafBlind, and ~~Hard-of-Hearing~~ Hard of Hearing State Services Division.** The commissioners of commerce, education, employment and economic development, and health shall ~~advise~~ partner with the commissioner of human services on the interagency activities of the Deaf, DeafBlind, and ~~Hard-of-Hearing~~ Hard of Hearing State Services Division. This division ~~addresses the developmental and social-emotional needs of~~ provides services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing through a statewide network of programs, services, and supports. This division also advocates on behalf of and provides information and training about how to best serve persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing. The commissioner of human services shall coordinate the work of the interagency ~~advisers and~~ partners, receive legislative appropriations for the division, and provide grants through the division for programs, services, and supports for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing in identified areas of need such as deafblind services, family services, interpreting services, and mental health services.

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

Sec. 11. Minnesota Statutes 2022, section 256C.233, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** The Deaf, DeafBlind, and ~~Hard-of-Hearing~~ Hard of Hearing State Services Division shall:

(1) establish and maintain a statewide network of regional culturally and linguistically affirmative services for Minnesotans who are deaf, Minnesotans who are deafblind, and Minnesotans who are hard-of-hearing;

(2) work across divisions within the Department of Human Services, as well as with other agencies and counties, to ensure that there is an understanding of:

(i) the communication access challenges faced by persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing;

(ii) the best practices for accommodating and ~~mitigating~~ addressing communication access challenges; and

(iii) the legal requirements for providing access to and effective communication with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing;

(3) assess the supply and demand statewide for ~~interpreter~~ interpreting services and real-time captioning services, implement strategies to provide greater access to these services in areas without sufficient supply, and ~~build the base of~~ partner with interpreting service providers and real-time captioning service providers across the state;

(4) maintain a statewide information resource that includes contact information and professional ~~certification credentials~~ certifications of interpreting service providers and real-time captioning service providers;

(5) provide culturally and linguistically affirmative mental health services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing who:

(i) use a visual language such as American Sign Language, another sign language, or a tactile form of a visual language; or

(ii) otherwise need culturally and linguistically affirmative ~~therapeutic~~ mental health services;

(6) research and develop best practices and recommendations for emerging issues; and

(7) provide as much information as practicable on the division's stand-alone website in American Sign Language~~; and~~.

~~(8) report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services biennially, beginning on January 1, 2019, on the following:~~

~~(i) the number of regional service center staff, the location of the office of each staff person, other service providers with which they are colocated, the number of people served by each staff person and a breakdown of whether each person was served on-site or off-site,~~

~~and for those served off-site, a list of locations where services were delivered and the number who were served in-person and the number who were served via technology;~~

~~(ii) the amount and percentage of the division budget spent on reasonable accommodations for staff;~~

~~(iii) the number of people who use demonstration equipment and consumer evaluations of the experience;~~

~~(iv) the number of training sessions provided by division staff, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;~~

~~(v) the number of training sessions hosted at a division location provided by another service provider, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;~~

~~(vi) for each grant awarded, the amount awarded to the grantee and a summary of the grantee's results, including consumer evaluations of the services or products provided;~~

~~(vii) the number of people on waiting lists for any services provided by division staff or for services or equipment funded through grants awarded by the division;~~

~~(viii) the amount of time staff spent driving to appointments to deliver direct one-to-one client services in locations outside of the regional service centers; and~~

~~(ix) the regional needs and feedback on addressing service gaps identified by the advisory committees.~~

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

Sec. 12. Minnesota Statutes 2022, section 256C.24, subdivision 1, is amended to read:

Subdivision 1. **Location.** The Deaf, DeafBlind, and ~~Hard-of-Hearing~~ Hard of Hearing State Services Division shall establish at least six regional service centers for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing. The centers shall be distributed regionally to provide access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing in all parts of the state.

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

Sec. 13. Minnesota Statutes 2022, section 256C.24, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** Each regional service center shall:

(1) employ qualified staff to work with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing;

~~(1)~~ (2) establish connections and collaborations ~~and explore colocating~~ with other public and private entities providing services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing in the region;

~~(2)~~ (3) for those in need of services, assist in coordinating services between service providers and persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and make referrals to the services needed;

~~(3) employ staff trained to work with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing;~~

(4) if adequate or accessible services are not available from another public or private service provider in the region, provide individual culturally and linguistically affirmative assistance with service supports and solutions to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families~~. Individual culturally affirmative assistance may be provided using technology only in areas of the state where a person has access to sufficient quality telecommunications or broadband services to allow effective communication. When a person who is deaf, a person who is deafblind, or a person who is hard-of-hearing does not have access to sufficient telecommunications or broadband service, individual assistance shall be available in person~~;

(5) identify regional training and resource needs~~, work with deaf and hard-of-hearing services training staff, and collaborate with others to~~ and deliver training and resources for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and other service providers about subjects including the persons' rights under the law, American Sign Language, and the impact of hearing loss and options for accommodating it;

(6) have a mobile or permanent lab where persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection of ~~modern~~ assistive technology, telecommunications equipment, and other technology and equipment to determine what would best meet the persons' needs;

(7) collaborate with ~~the Resource Center for the Deaf and Hard-of-Hearing Persons, other divisions of~~ the Department of Education and local school districts to ~~develop and deliver programs and services for~~ provide information and resources to families with children who are deaf, children who are deafblind, or children who are hard-of-hearing and to ~~support~~ school personnel serving these children;

(8) provide training, resources, and consultation to ~~the social service or income maintenance staff employed by counties or by organizations with whom counties contract for services to ensure that~~ human services providers about communication ~~barriers which prevent~~ access and other needs of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~from using services are removed~~;

~~(9) provide training to human service agencies in the region regarding program access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing;~~

~~(10)~~ (9) assess the ongoing need and supply of services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing in all parts of the state~~,~~; annually consult with the division's advisory committees to identify regional needs and solicit feedback on addressing service gaps~~,~~; and ~~cooperate~~ collaborate with public and private service providers ~~to develop these services~~ on service solutions;

~~(11)~~ (10) provide culturally and linguistically affirmative mental health services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing who:

(i) use a visual language such as American Sign Language, another sign language, or a tactile form of a visual language; or

(ii) otherwise need culturally and linguistically affirmative ~~therapeutic~~ mental health services; and

~~(12)~~ (11) establish partnerships with state and regional entities statewide ~~that have the technological capacity~~ to provide Minnesotans with virtual access to the division's services and ~~division-sponsored~~ training ~~via~~ through technology.

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

Sec. 14. Minnesota Statutes 2022, section 256C.24, subdivision 3, is amended to read:

Subd. 3. **Advisory committee.** The director of the Deaf, DeafBlind, and ~~Hard-of-Hearing~~ Hard of Hearing State Services Division shall appoint eight advisory committees of up to nine persons per advisory committee. Each committee shall represent a specific region of the state. The director shall determine the boundaries of each advisory committee region. The committees shall advise the director on the needs of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing and service gaps in the region of the state the committee represents. Members shall include persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, persons who have communication disabilities, parents of children who are deaf, parents of children who are deafblind, and parents of children who are hard-of-hearing, parents of children who have communication

disabilities, and representatives of county and regional human services, including representatives of private service providers. At least 50 percent of the members must be deaf or deafblind or hard-of-hearing or have a communication disability. Committee members shall serve for a three-year term~~, and may be appointed to~~. Committee members shall serve no more than three consecutive terms and no more than nine years in total. Each advisory committee shall elect a chair. The director of the Deaf, DeafBlind, and ~~Hard-of-Hearing~~ Hard of Hearing State Services Division ~~shall~~ may assign staff to serve as nonvoting members of the committee. Members shall not receive a per diem. Otherwise, the compensation, removal of members, and filling of vacancies on the committee shall be as provided in section 15.0575.

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

Sec. 15. Minnesota Statutes 2022, section 256C.26, is amended to read:

256C.26 EMPLOYMENT SERVICES.

The commissioner of employment and economic development shall work with the Deaf, DeafBlind, and ~~Hard-of-Hearing~~ Hard of Hearing State Services Division to develop and implement a plan to deal with the underemployment of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~.

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

Sec. 16. Minnesota Statutes 2022, section 256C.261, is amended to read:

256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND.

(a) The commissioner of human services shall use at least ~~35~~ 60 percent of the deafblind services biennial base level grant funding for programs, services, and ~~other~~ supports for ~~a child~~ adults who are deafblind and for children who ~~is~~ are deafblind and the ~~child's family~~ children's families. ~~The commissioner shall use at least 25 percent of the deafblind services biennial base level grant funding for services and other supports for an adult who is deafblind.~~

The commissioner shall award grants for the purposes of~~:~~

~~(1)~~ providing programs, services, and supports to persons who are deafblind~~; and~~.

~~(2) developing and providing training to counties and the network of senior citizen service providers. The purpose of the training grants is to teach counties how to use existing programs that capture federal financial participation to meet the needs of eligible persons who are deafblind and to build capacity of senior service programs to meet the needs of seniors with a dual sensory hearing and vision loss.~~

(b) The commissioner may make grants:

(1) for services and training provided by organizations to persons who are deafblind; ~~and~~

(2) to develop and administer consumer-directed services~~.~~ for persons who are deafblind; and

(3) to develop and provide training to counties and service providers on how to meet the needs of persons who are deafblind.

(c) Consumer-directed services ~~shall~~ must be provided in whole by grant-funded providers. ~~The Deaf and Hard-of-Hearing Services Division's regional service centers shall not provide any aspect of a grant-funded consumer-directed services program.~~

~~(d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under paragraph (a).~~

~~(e)~~ (d) Deafblind service providers may, but are not required to, provide ~~intervenor~~ intervener services as part of the service package provided with grant funds under this section. Intervener services include services provided by a family and community intervener as described in paragraph ~~(f)~~ (e).

~~(f)~~ (e) The family and community intervener, as defined in section 256C.23, subdivision 7, provides services to open channels of communication between the child and others; facilitates the development or use of receptive and expressive communication skills by the child; and develops and maintains a trusting, interactive relationship that promotes social and emotional well-being. The family and community intervener also provides access to information and the environment~~,~~ and facilitates opportunities for learning and development. A family and community intervener must have specific training in deafblindness, building language and communication skills, and intervention strategies.

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

Sec. 17. Minnesota Statutes 2022, section 256C.28, subdivision 1, is amended to read:

Subdivision 1. **Membership.** (a) The Commission of the Deaf, DeafBlind and Hard of Hearing consists of ~~seven~~ ten members appointed at large and one member each from ~~each~~ up to five advisory ~~committee~~ committees established under section 256C.24, subdivision 3. At least 50 percent of the voting members must be deaf or deafblind or hard-of-hearing. Members shall include ~~persons who are deaf, deafblind, and hard-of-hearing, parents~~ at least one parent or guardian of ~~children~~ a person who ~~are~~ is deaf, deafblind, ~~and~~ or

hard-of-hearing~~, and representatives of county and regional human services, including representatives of private service providers~~. The commissioners of education, health, human rights, and employment and economic development and the director of the Deaf and Hard-of-Hearing Services Division in the Department of Human Services, or their designees, shall serve as ex officio, nonvoting members of the commission. The commission may appoint additional ex officio members from other bureaus, divisions, or sections of state departments directly concerned with the provision of services to persons who are deaf, deafblind, or hard-of-hearing.

(b) ~~Commission~~ Voting members of the commission are appointed by the governor for a four-year term and until successors are appointed and qualify. ~~Commission~~ Voting members of the commission shall serve no more than three consecutive full terms~~, and no more than 12 years in total~~.

(c) Annually, by January 31, the commission shall select one member as chair and one member as vice-chair to serve until January 31 of the following year or until the commission selects a new chair or vice-chair, whichever occurs later.

ARTICLE 3
AGING SERVICES

Section 1. Minnesota Statutes 2022, section 144A.20, subdivision 4, is amended to read:

Subd. 4. **Assisted living director qualifications; ongoing training.** (a) The Board of Executives for Long Term Services and Supports may issue licenses to qualified persons as an assisted living director and shall approve training and examinations. No license shall be issued to a person as an assisted living director unless that person:

(1) is eligible for licensure;

(2) has applied for licensure under this subdivision within ~~six months~~ 30 days of hire as an assisted living director; and

(3) has satisfactorily met standards set by the board ~~or is scheduled to complete the training in paragraph (b) within one year of hire~~. The standards shall be designed to assure that assisted living directors are individuals who, by training or experience, are qualified to serve as assisted living directors.

(b) In order to be qualified to serve as an assisted living director, an individual must:

(1) have completed an approved training course and passed an examination approved by the board that is designed to test for competence and that includes assisted living facility laws in Minnesota; or

(2)(i) currently be licensed in the state of Minnesota as a nursing home administrator or have been validated as a qualified health services executive by the National Association of Long Term Care Administrator Boards; and

(ii) have core knowledge of assisted living facility laws~~; or~~.

~~(3) apply for licensure by July 1, 2021, and satisfy one of the following:~~

~~(i) have a higher education degree in nursing, social services, or mental health, or another professional degree with training specific to management and regulatory compliance;~~

~~(ii) have at least three years of supervisory, management, or operational experience and higher education training applicable to an assisted living facility;~~

~~(iii) have completed at least 1,000 hours of an executive in training program provided by an assisted living director licensed under this subdivision; or~~

~~(iv) have managed a housing with services establishment operating under assisted living title protection for at least three years.~~

(c) An assisted living director must receive at least 30 hours of ~~training~~ continuing education every two years on topics relevant to the operation of an assisted living facility and the needs of its residents. An assisted living director must maintain records of the training required by this paragraph for at least the most recent three-year period and must provide these records to Department of Health surveyors upon request. Continuing education earned to maintain another professional license, such as a nursing home administrator license, nursing license, social worker license, mental health professional license, or real estate license, may be used to satisfy this requirement when the continuing education is relevant to the assisted living services offered and residents served at the assisted living facility.

Sec. 3. Minnesota Statutes 2022, section 144G.30, subdivision 5, is amended to read:

Subd. 5. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the facility must:

(1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.; and

(2) post or otherwise make available, in a manner or location readily accessible to residents and others, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order.

(d) After the plan of correction is posted or otherwise made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format upon request.

EFFECTIVE DATE. This section is effective August 1, 2024, and applies to correction orders issued on or after that date.

Sec. 4. Minnesota Statutes 2022, section 256.975, subdivision 7e, is amended to read:

Subd. 7e. **Long-term care options counseling ~~for assisted living~~ at critical care transitions.** (a) The purpose of long-term care options counseling ~~for assisted living~~ is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings. ~~Prospective residents maintain the right to choose assisted living if that option is their preference.~~ Reaching people before a crisis and during care transitions is important to ensure quality of care and life, prevent unnecessary hospitalizations and readmissions, reduce the burden on the health care system, reduce costs, and support personal preferences.

(b) ~~Licensed assisted living facilities shall inform each prospective resident or the prospective resident's designated or legal representative of the availability of long-term care options counseling for assisted living and the need to receive and verify the counseling prior~~

~~to signing a contract. Long-term care options counseling for assisted living is provided as determined by the commissioner of human services. The service is delivered under a partnership between lead agencies as defined in subdivision 10, paragraph (g), and the Area Agencies on Aging, and is a point of entry to a combination of telephone-based long-term care options counseling provided by Senior LinkAge Line and in-person long-term care consultation provided by lead agencies. The point of entry service must be provided within five working days of the request of the prospective resident as follows~~ Counseling must be delivered by Senior LinkAge Line either by telephone or in-person. Counseling must:

~~(1) the counseling shall be conducted with the prospective resident, or in the alternative, the resident's designated or legal representative, if:~~

~~(i) the resident verbally requests; or~~

~~(ii) the assisted living facility has documentation of the designated or legal representative's authority to enter into a lease or contract on behalf of the prospective resident and accepts the documentation in good faith;~~

~~(2) the counseling shall~~ (1) be performed in a manner that provides objective and complete information;

~~(3) the counseling must~~ (2) include a review of the ~~prospective resident's reasons for considering assisted living services, the prospective resident's~~ person's personal goals, ~~a~~ discussion of the ~~prospective resident's~~ person's immediate and projected long-term care needs, and alternative community services or settings that may meet the ~~prospective resident's~~ person's needs; and

~~(4) the prospective resident must be informed of the availability of an in-person visit from a long-term care consultation team member at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs; and~~

~~(5) verification of counseling shall be generated and provided to the prospective resident by Senior LinkAge Line upon completion of the telephone-based counseling~~ (3) include the counseling and referral protocols in subdivision 7, paragraph (b), clauses (11) to (13).

(c) An assisted living facility licensed under chapter 144G ~~shall:~~

~~(1)~~ must inform each prospective resident or the prospective resident's designated or legal representative of the availability of and contact information for long-term care options counseling services under this subdivision~~;~~ by providing Senior LinkAge Line information at the facility tour.

~~(2) receive a copy of the verification of counseling prior to executing a contract with the prospective resident; and~~

~~(3) retain a copy of the verification of counseling as part of the resident's file.~~

(d) ~~Emergency admissions to licensed assisted living facilities prior to consultation under paragraph (b) are permitted according to policies established by the commissioner.~~ Prior to discharge, hospitals must refer older adults who are at risk of nursing home placement to the Senior LinkAge Line for long-term care options counseling. Hospitals must make these referrals using referral protocols and processes developed under subdivision 7.

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

Sec. 5. Minnesota Statutes 2022, section 256B.69, is amended by adding a subdivision to read:

Subd. 6h. **Continuity of care for seniors receiving personal assistance.** (a) If an individual 65 years of age or older is receiving personal assistance from the same agency continuously during the six months prior to being newly enrolled with any managed care or county-based purchasing plan, the managed care plan or county-based purchasing plan with which the individual is newly enrolled must offer the agency a contract for the purposes of allowing the enrollee to receive any personal assistance covered under the terms of the plan from the enrollee's current agency, provided the enrollee continues to live in the service area of the enrollee's current agency.

(b) This subdivision applies only if the enrollee's current agency agrees to accept as payment in full the managed care plan's or county-based purchasing plan's in-network reimbursement rate for the same covered service at the time the service is provided, and agrees to enter into a managed care plan's or county-based purchasing plan's contract for personal assistance.

(c) For the purposes of this subdivision, "agency" means any of the following:

(1) an agency provider as described in section 256B.85;

(2) a financial management services provider for an enrollee who directly employs direct care staff through the community first services and supports budget model or through the consumer-directed community supports option available under the elderly waiver; or

(3) a personal care assistance provider agency as defined under section 256B.0659, subdivision 1, paragraph (l).

(d) For the purposes of this subdivision, "personal assistance" means any of the following:

(1) community first services and supports, extended community first services and supports, or enhanced rate community first services and supports under section 256B.85;

(2) personal assistance provided through the consumer-directed community supports option available under the elderly waiver; or

(3) personal care assistance services, extended personal care assistance services, or enhanced rate personal care assistance services under section 256B.0659.

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

Sec. 6. Minnesota Statutes 2022, section 256R.08, subdivision 1, is amended to read:

Subdivision 1. **Reporting of financial statements.** (a) No later than February 1 of each year, a nursing facility must:

(1) provide the state agency with a copy of its ~~audited financial statements or its~~ working trial balance;

(2) provide the state agency with a copy of its audited financial statements for each year an audit is conducted;

~~(2)~~ (3) provide the state agency with a statement of ownership for the facility;

~~(3)~~ (4) provide the state agency with separate, audited financial statements ~~or~~ and working trial balances for every other facility owned in whole or in part by an individual or entity that has an ownership interest in the facility;

(5) provide the state agency with information regarding whether the licensee or a general partner, director, or officer of the licensee controls or has an ownership interest of five percent or more in a related organization that provides any services, facilities, or supplies to the nursing facility;

~~(4)~~ (6) upon request, provide the state agency with separate, audited financial statements ~~or~~ and working trial balances for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

~~(5)~~ (7) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility; and

~~(6)~~ (8) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs.

(b) If the licensee or the general partner, director, or officer of the licensee controls or has an interest as described in paragraph (a), clause (5), the licensee must disclose all services, facilities, or supplies provided to the nursing facility; the number of individuals who provide services, facilities, or supplies at the nursing facility; and any other information requested by the state agency.

~~(b)~~ (c) Audited financial statements submitted under ~~paragraph~~ paragraphs (a) and (b) must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the public accountant's report. Public accountants must conduct audits in accordance with chapter 326A. The cost of an audit must not be an allowable cost unless the nursing facility submits its audited financial statements in the manner otherwise specified in this subdivision. A nursing facility must permit access by the state agency to the public accountant's audit work papers that support the audited financial statements submitted under ~~paragraph~~ paragraphs (a) and (b).

~~(c)~~ (d) Documents or information provided to the state agency pursuant to this subdivision must be public unless prohibited by the Health Insurance Portability and Accountability Act or any other federal or state regulation. Data, notes, and preliminary drafts of reports created, collected, and maintained by the audit offices of government entities, or persons performing audits for government entities, and relating to an audit or investigation are confidential data on individuals or protected nonpublic data until the final report has been published or the audit or investigation is no longer being pursued actively, except that the data must be disclosed as required to comply with section 6.67 or 609.456.

~~(d)~~ (e) If the requirements of paragraphs (a) ~~and~~, (b), and (c) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting period and the reduction must continue until the requirements are met.

(f) Licensees must provide the information required in this section to the commissioner in a manner prescribed by the commissioner.

(g) For purposes of this section, "related organization" and "control" have the meanings given in section 256R.02, subdivision 43.

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

Sec. 7. Minnesota Statutes 2022, section 256R.08, is amended by adding a subdivision to read:

Subd. 5. **Notice of costs associated with leases, rent, and use of land or other real property by nursing homes.** (a) Nursing homes must annually report to the commissioner, in a manner determined by the commissioner, their cost associated with leases, rent, and use of land or other real property and any other related information requested by the state agency.

(b) A nursing facility that violates this subdivision is subject to the penalties and procedures under section 256R.04, subdivision 7.

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

Sec. 8. 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 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.~~

Sec. 9. Minnesota Statutes 2022, section 256S.205, is amended by adding a subdivision to read:

Subd. 7. **Expiration.** This section expires on the first December 31 that occurs at least 23 months following the effective date of the repeal, expiration, or removal of all rate phase-in provisions in section 256S.2101. The commissioner of human services shall inform the revisor of statutes when this section expires.

Sec. 10. **REPEALER.**

(a) Minnesota Statutes 2022, section 256.975, subdivisions 7f and 7g, are repealed.

(b) Minnesota Statutes 2022, section 256R.18, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2024. Paragraph (b) is effective July 1, 2024.

ARTICLE 4
SUBSTANCE USE DISORDER SERVICES

Section 1. Minnesota Statutes 2022, section 148F.025, subdivision 2, is amended to read:

Subd. 2. **Education requirements for licensure.** An applicant for licensure must submit evidence satisfactory to the board that the applicant has:

(1) received a bachelor's or master's degree from an accredited school or educational program; and

(2) received 18 semester credits or 270 clock hours of academic course work and 880 clock hours of supervised alcohol and drug counseling practicum from an accredited school or education program. The course work and practicum do not have to be part of the bachelor's degree earned under clause (1). The academic course work must be in the following areas:

(i) an overview of the transdisciplinary foundations of alcohol and drug counseling, including theories of chemical dependency, the continuum of care, and the process of change;

(ii) pharmacology of substance abuse disorders and the dynamics of addiction, including substance use disorder treatment with medications for opioid use disorder;

(iii) professional and ethical responsibilities;

(iv) multicultural aspects of chemical dependency;

(v) co-occurring disorders; and

(vi) the core functions defined in section 148F.01, subdivision 10.

Sec. 2. Minnesota Statutes 2022, section 245F.02, subdivision 17, is amended to read:

Subd. 17. **Peer recovery support services.** "Peer recovery support services" means ~~mentoring and education, advocacy, and nonclinical recovery support provided by a recovery peer~~ services provided according to section 245F.08, subdivision 3.

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

Sec. 3. Minnesota Statutes 2022, section 245F.02, subdivision 21, is amended to read:

Subd. 21. **Recovery peer.** "Recovery peer" means a person who has progressed in the person's own recovery from substance use disorder and is willing to serve as a peer to assist others in their recovery and is qualified according to section 245F.15, subdivision 7.

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

Sec. 4. Minnesota Statutes 2022, section 245F.08, subdivision 3, is amended to read:

Subd. 3. **Peer recovery support services.** ~~(a) Peers in recovery serve as mentors or recovery-support partners for individuals in recovery, and may provide encouragement, self-disclosure of recovery experiences, transportation to appointments, assistance with finding resources that will help locate housing, job search resources, and assistance finding and participating in support groups.~~

~~(b) Peer recovery support services are provided by a recovery peer and must be supervised by the responsible staff person.~~

Peer recovery support services must meet the requirements in section 245G.07, subdivision 2, clause (8), and must be provided by a person who is qualified according to the requirements in section 245F.15, subdivision 7.

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

Sec. 5. Minnesota Statutes 2022, section 245F.15, subdivision 7, is amended to read:

Subd. 7. **Recovery peer qualifications.** Recovery peers must:

~~(1) be at least 21 years of age and have a high school diploma or its equivalent;~~

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

~~(3) have completed a curriculum designated by the commissioner that teaches specific skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and~~

~~(4) receive supervision in areas specific to the domains of their role by qualified supervisory staff.~~

(1) meet the qualifications in section 245I.04, subdivision 18; and

(2) provide services according to the scope of practice established in section 245I.04, subdivision 19, under the supervision of an alcohol and drug counselor.

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

Sec. 11. Minnesota Statutes 2022, section 245G.031, subdivision 2, is amended to read:

Subd. 2. **Qualifying accreditation; determination of same and similar standards.** (a) The commissioner must accept a qualifying accreditation from an accrediting body listed in paragraph (c) after determining, in consultation with the accrediting body and license holders, which of the accrediting body's standards ~~that~~ are the same as or similar to the licensing requirements in this chapter. In determining whether standards of an accrediting body are the same as or similar to licensing requirements under this chapter, the commissioner shall give due consideration to the existence of a standard that aligns in whole or in part to a licensing standard.

(b) Upon request by a license holder, the commissioner may allow the accrediting body to monitor for compliance with licensing requirements under this chapter that are determined to be neither the same as nor similar to those of the accrediting body.

(c) For purposes of this section, "accrediting body" means The Joint Commission.

(d) Qualifying accreditation only applies to the license holder's licensed programs that are included in the accrediting body's survey during each survey period.

Sec. 12. Minnesota Statutes 2022, section 245G.04, is amended by adding a subdivision to read:

Subd. 3. **Opioid educational material.** (a) If a client is identified as having opioid use issues, the license holder must provide opioid educational material to the client on the day of service initiation. The license holder must use the opioid educational material approved by the commissioner that contains information on:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk and recognition of opioid overdose; and

(4) the use, availability, and administration of an opiate antagonist to respond to opioid overdose.

(b) If the client is identified as having opioid use issues at a later date, the required educational material must be provided at that time.

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

Sec. 14. Minnesota Statutes 2023 Supplement, section 245G.05, subdivision 3, is amended to read:

Subd. 3. **Comprehensive assessment requirements.** ~~(a)~~ A comprehensive assessment must meet the requirements under section 245I.10, subdivision 6, paragraphs (b) and (c). It must also include:

(1) a diagnosis of a substance use disorder or a finding that the client does not meet the criteria for a substance use disorder;

(2) a determination of whether the individual screens positive for co-occurring mental health disorders using a screening tool approved by the commissioner pursuant to section 245.4863;

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

(4) a recommendation for the ASAM level of care identified in section 254B.19, subdivision 1.

~~(b) If the individual is assessed for opioid use disorder, the program must provide educational material to the client within 24 hours of service initiation on:~~

~~(1) risks for opioid use disorder and dependence;~~

~~(2) treatment options, including the use of a medication for opioid use disorder;~~

~~(3) the risk and recognition of opioid overdose; and~~

~~(4) the use, availability, and administration of an opiate antagonist to respond to opioid overdose.~~

~~If the client is identified as having opioid use disorder at a later point, the required educational material must be provided at that point. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.~~

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

Sec. 22. Minnesota Statutes 2023 Supplement, section 245G.09, subdivision 3, is amended to read:

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

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65,

subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section ~~245G.05~~ 245G.04, subdivision 3~~, paragraph (b)~~;

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2023 Supplement, section 245G.11, subdivision 10, is amended to read:

Subd. 10. **Student interns and former students.** (a) A qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each assessment, individual treatment plan, and treatment plan review prepared by a student intern.

(b) An alcohol and drug counselor must supervise and be responsible for a treatment service performed by a former student and must review and sign each assessment, individual treatment plan, and treatment plan review prepared by the former student.

(c) A student intern or former student must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be ~~students,~~ student interns or former students~~, or licensing candidates~~ with time documented to be directly related to the provision of treatment services for which the staff are authorized.

Sec. 25. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 2, is amended to read:

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

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from intended use of the medication.

(c) "Guest dose" means administration of a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a practitioner licensed to practice medicine in the jurisdiction that the opioid treatment program is located who assumes responsibility for administering all medical services performed by the program, either by performing the services directly or by delegating specific responsibility to a practitioner of the opioid treatment program.

(e) "Medication used for the treatment of opioid use disorder" means a medication approved by the Food and Drug Administration for the treatment of opioid use disorder.

(f) "Minnesota health care programs" has the meaning given in section 256B.0636.

(g) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under this chapter.

(h) "Practitioner" means a staff member holding a current, unrestricted license to practice medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing and is currently registered with the Drug Enforcement Administration to order or dispense controlled substances in Schedules II to V under the Controlled Substances Act, United States Code, title 21, part B, section 821. ~~Practitioner includes an advanced practice registered nurse and physician assistant if the staff member receives a variance by the state opioid treatment authority under section 254A.03 and the federal Substance Abuse and Mental Health Services Administration.~~

(i) "Unsupervised use" means the use of a medication for the treatment of opioid use disorder dispensed for use by a client outside of the program setting.

Sec. 26. Minnesota Statutes 2022, section 245G.22, subdivision 6, is amended to read:

Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid use disorder to the illicit market, medication dispensed to a client for unsupervised use shall be subject to the requirements of this subdivision. Any client in an opioid treatment program may receive ~~a single unsupervised use dose for a day that the clinic is closed for business, including Sundays and state and federal holidays~~ individualized unsupervised use doses as ordered for days that the clinic is closed for business, including one weekend day and state and federal holidays, no matter

the client's length of time in treatment, as allowed under Code of Federal Regulations, title 42, section 8.12(i)(1).

(b) For unsupervised use doses beyond those allowed in paragraph (a), a practitioner with authority to prescribe must review and document the criteria in ~~this paragraph and paragraph (c)~~ Code of Federal Regulations, title 42, section 8.12(i)(2), when determining whether dispensing medication for a client's unsupervised use is safe and when it is appropriate to implement, increase, or extend the amount of time between visits to the program. ~~The criteria are:~~

~~(1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics, and alcohol;~~

~~(2) regularity of program attendance;~~

~~(3) absence of serious behavioral problems at the program;~~

~~(4) absence of known recent criminal activity such as drug dealing;~~

~~(5) stability of the client's home environment and social relationships;~~

~~(6) length of time in comprehensive maintenance treatment;~~

~~(7) reasonable assurance that unsupervised use medication will be safely stored within the client's home; and~~

~~(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.~~

(c) The determination, including the basis of the determination must be documented in the client's medical record.

Sec. 27. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 17, is amended to read:

Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the policies and procedures required in this subdivision.

(b) For a program that is not open every day of the year, the license holder must maintain a policy and procedure that covers requirements under section 245G.22, ~~subdivisions 6 and 7~~ subdivision 6. Unsupervised use of medication used for the treatment of opioid use disorder for days that the program is closed for business, including ~~but not limited to Sundays~~ one weekend day and state and federal holidays, must meet the requirements under section 245G.22, ~~subdivisions 6 and 7~~ subdivision 6.

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of diversion. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for performing diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication, excluding clients approved solely under subdivision 6, paragraph (a), to require clients to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid use disorder treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the client's record. The medical director must be informed of each outcome that results in a situation in which a possible diversion issue was identified.

(d) Medication used for the treatment of opioid use disorder must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. If a medication order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits an assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor the person administering or dispensing the medication for compliance with state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's determination of noncompliance.

~~(e) A counselor in an opioid treatment program must not supervise more than 50 clients.~~

~~(f) Notwithstanding paragraph (e), From July 1, 2023, to June 30, 2024, a counselor in an opioid treatment program may supervise up to 60 clients. The license holder may continue to serve a client who was receiving services at the program on June 30, 2024, at a counselor to client ratio of up to one to 60 and is not required to discharge any clients in order to return to the counselor to client ratio of one to 50. The license holder may not, however, serve a new client after June 30, 2024, unless the counselor who would supervise the new client is supervising fewer than 50 existing clients.~~

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

Sec. 28. Minnesota Statutes 2023 Supplement, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **Comprehensive assessments.** (a) An eligible vendor under section 254B.05 conducting a comprehensive assessment for an individual seeking treatment shall ~~approve~~ recommend the nature, intensity level, and duration of treatment service if a need for services is indicated, but the individual assessed can access any enrolled provider that is licensed to provide the level of service authorized, including the provider or program that completed the assessment. If an individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

(b) When a comprehensive assessment is completed while the individual is in a substance use disorder treatment program, the comprehensive assessment must meet the requirements of section 245G.05.

(c) When a comprehensive assessment is completed for purposes of payment under section 254B.05, subdivision 1, paragraphs (b), (c), or (h), or if the assessment is completed prior to service initiation by a licensed substance use disorder treatment program licensed under chapter 245G or applicable Tribal license, the assessor must:

(1) include all components under section 245G.05, subdivision 3;

(2) provide the assessment within five days of request or refer the individual to other locations where they may access this service sooner;

(3) provide information on payment options for substance use disorder services when the individual is uninsured or underinsured;

(4) provide the individual with a notice of privacy practices;

(5) provide a copy of the completed comprehensive assessment, upon request;

(6) provide resources and contact information for the level of care being recommended; and

(7) provide an individual diagnosed with an opioid use disorder with educational material approved by the commissioner that contains information on:

(i) risks for opioid use disorder and opioid dependence;

(ii) treatment options, including the use of a medication for opioid use disorder;

(iii) the risk and recognition of opioid overdose; and

(iv) the use, availability, and administration of an opiate antagonist to respond to opioid overdose.

Sec. 29. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 6, is amended to read:

Subd. 6. **Local agency to determine client financial eligibility.** (a) The local agency shall determine a client's financial eligibility for the behavioral health fund according to section 254B.04, subdivision 1a, with the income calculated prospectively for one year from the date of ~~comprehensive assessment~~ request. The local agency shall pay for eligible clients according to chapter 256G. ~~The local agency shall enter the financial eligibility span within ten calendar days of request.~~ Client eligibility must be determined using only forms prescribed by the ~~department~~ commissioner unless the local agency has a reasonable basis for believing that the information submitted on a form is false. To determine a client's eligibility, the local agency must determine the client's income, the size of the client's household, the availability of a third-party payment source, and a responsible relative's ability to pay for the client's substance use disorder treatment.

(b) A client who is a minor child must not be deemed to have income available to pay for substance use disorder treatment, unless the minor child is responsible for payment under section 144.347 for substance use disorder treatment services sought under section 144.343, subdivision 1.

(c) The local agency must determine the client's household size as follows:

(1) if the client is a minor child, the household size includes the following persons living in the same dwelling unit:

(i) the client;

(ii) the client's birth or adoptive parents; and

(iii) the client's siblings who are minors; and

(2) if the client is an adult, the household size includes the following persons living in the same dwelling unit:

(i) the client;

(ii) the client's spouse;

(iii) the client's minor children; and

(iv) the client's spouse's minor children.

For purposes of this paragraph, household size includes a person listed in clauses (1) and (2) who is in an out-of-home placement if a person listed in clause (1) or (2) is contributing to the cost of care of the person in out-of-home placement.

(d) The local agency must determine the client's current prepaid health plan enrollment, the availability of a third-party payment source, including the availability of total payment, partial payment, and amount of co-payment.

(e) The local agency must provide the required eligibility information to the department in the manner specified by the department.

(f) The local agency shall require the client and policyholder to conditionally assign to the department the client and policyholder's rights and the rights of minor children to benefits or services provided to the client if the department is required to collect from a third-party pay source.

(g) The local agency must redetermine a client's eligibility for the behavioral health fund every 12 months.

(h) A client, responsible relative, and policyholder must provide income or wage verification, household size verification, and must make an assignment of third-party payment rights under paragraph (f). If a client, responsible relative, or policyholder does not comply with the provisions of this subdivision, the client is ineligible for behavioral health fund payment for substance use disorder treatment, and the client and responsible relative must be obligated to pay for the full cost of substance use disorder treatment services provided to the client.

Sec. 30. Minnesota Statutes 2023 Supplement, section 254B.04, is amended by adding a subdivision to read:

Subd. 6a. **Span of eligibility.** The local agency must enter the financial eligibility span within five business days of a request. If the comprehensive assessment is completed within the timelines required under chapter 245G, then the span of eligibility must begin on the date services were initiated. If the comprehensive assessment is not completed within the timelines required under chapter 245G, then the span of eligibility must begin on the date the comprehensive assessment was completed.

Sec. 31. Minnesota Statutes 2023 Supplement, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure or certification required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by Tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8.

(d) A recovery community organization that meets the requirements of clauses (1) to (10) and meets ~~membership~~ certification or accreditation requirements of the ~~Association of Recovery Community Organizations,~~ Alliance for Recovery Centered Organizations, the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide recovery community organization identified by the commissioner is an eligible vendor of peer support services. Eligible vendors under this paragraph must:

(1) be nonprofit organizations;

(2) be led and governed by individuals in the recovery community, with more than 50 percent of the board of directors or advisory board members self-identifying as people in personal recovery from substance use disorders;

(3) primarily focus on recovery from substance use disorders, with missions and visions that support this primary focus;

(4) be grassroots and reflective of and engaged with the community served;

(5) be accountable to the recovery community through processes that promote the involvement and engagement of, and consultation with, people in recovery and their families, friends, and recovery allies;

(6) provide nonclinical peer recovery support services, including but not limited to recovery support groups, recovery coaching, telephone recovery support, skill-building groups, and harm-reduction activities;

(7) allow for and support opportunities for all paths toward recovery and refrain from excluding anyone based on their chosen recovery path, which may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based paths;

(8) be purposeful in meeting the diverse needs of Black, Indigenous, and people of color communities, including board and staff development activities, organizational practices, service offerings, advocacy efforts, and culturally informed outreach and service plans;

(9) be stewards of recovery-friendly language that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma; and

(10) maintain an employee and volunteer code of ethics and easily accessible grievance procedures posted in physical spaces, on websites, or on program policies or forms.

(e) Recovery community organizations approved by the commissioner before June 30, 2023, shall retain their designation as recovery community organizations.

(f) A recovery community organization that is aggrieved by an accreditation or membership determination and believes it meets the requirements under paragraph (d) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (15), for reconsideration as an eligible vendor.

(g) All recovery community organizations must be certified or accredited by an entity listed in paragraph (d) by January 1, 2025.

~~(g)~~ (h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by Tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

~~(h)~~ (i) Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed

according to section 245G.05 and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

Sec. 32. Minnesota Statutes 2023 Supplement, 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) those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to 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~~ section 254A.19, subdivision 3;

(3) 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) withdrawal management services provided according to chapter 245F;

(6) 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;

(7) substance use disorder treatment services with medications for opioid use disorder provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or under an applicable Tribal license;

~~(7)~~ (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;

~~(8)~~ (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 ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are 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

~~(9)~~ (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) is licensed under chapter 245A and sections 245G.01 to 245G.19; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to ~~two hours~~ one hour per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

(5) programs that offer services to individuals with co-occurring mental health and substance use disorder problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

~~(ii) 25 percent of the counseling staff are licensed mental health professionals under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;~~ (ii) the program employs a mental health professional as defined in section 245I.04, subdivision 2;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance use disorder and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

(i) Payment for substance use disorder services under this section must start from the day of service initiation, when the comprehensive assessment is completed within the required timelines.

(j) A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence.

(k) Hours in a treatment week may be reduced in observance of federally recognized holidays.

EFFECTIVE DATE. This section is effective August 1, 2024, except the amendments to paragraph (b), clause (1), items (v) to (vii), are effective August 1, 2024, or upon federal approval, whichever occurs later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 33. Minnesota Statutes 2023 Supplement, section 254B.181, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** All sober homes must comply with applicable state laws and regulations and local ordinances related to maximum occupancy, fire safety, and sanitation. In addition, all sober homes must:

(1) maintain a supply of an opiate antagonist in the home in a conspicuous location and post information on proper use;

(2) have written policies regarding access to all prescribed medications;

(3) have written policies regarding evictions;

(4) return all property and medications to a person discharged from the home and retain the items for a minimum of 60 days if the person did not collect them upon discharge. The owner must make an effort to contact persons listed as emergency contacts for the discharged person so that the items are returned;

(5) document the names and contact information for persons to contact in case of an emergency or upon discharge and notification of a family member, or other emergency contact designated by the resident under certain circumstances, including but not limited to death due to an overdose;

(6) maintain contact information for emergency resources in the community to address mental health and health emergencies;

(7) have policies on staff qualifications and prohibition against fraternization;

(8) ~~have a policy on whether the use of medications for opioid use disorder is permissible~~ permit residents to use, as directed by a licensed prescriber, one or more legally prescribed and dispensed or administered pharmacotherapies approved by the United States Food and Drug Administration for the treatment of opioid use disorder and other nonaddictive medications approved by the United States Food and Drug Administration to treat co-occurring substance use disorders and mental health conditions;

(9) have a fee schedule and refund policy;

(10) have rules for residents;

(11) have policies that promote resident participation in treatment, self-help groups, or other recovery supports;

(12) have policies requiring abstinence from alcohol and illicit drugs; and

(13) distribute the sober home bill of rights.

Sec. 34. Minnesota Statutes 2023 Supplement, section 254B.19, subdivision 1, is amended to read:

Subdivision 1. **Level of care requirements.** For each client assigned an ASAM level of care, eligible vendors must implement the standards set by the ASAM for the respective level of care. Additionally, vendors must meet the following requirements:

(1) For ASAM level 0.5 early intervention targeting individuals who are at risk of developing a substance-related problem but may not have a diagnosed substance use disorder, early intervention services may include individual or group counseling, treatment coordination, peer recovery support, screening brief intervention, and referral to treatment provided according to section 254A.03, subdivision 3, paragraph (c).

(2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per week of skilled treatment services and adolescents must receive up to five hours per week. Services must be licensed according to section 245G.20 and meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week.

(3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours per week of skilled treatment services and adolescents must receive six or more hours per week. Vendors must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Peer recovery services and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week. If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or more of skilled treatment services. Services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Level 2.5 is for clients who need daily monitoring in a structured setting, as directed by the individual treatment plan and in accordance with the limitations in section 254B.05, subdivision 5, paragraph (h). If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs must provide ~~at least 5~~ between nine and 19 hours of skilled treatment services per week according to each client's specific treatment schedule, as directed by the individual treatment plan. Programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759.

(6) For ASAM level 3.3 clinically managed population-specific high-intensity residential clients, programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour staffing coverage. Programs must be enrolled as a disability responsive program as described in section 254B.01, subdivision 4b, and must specialize in serving persons with a traumatic brain injury or a cognitive impairment so significant, and the resulting level of impairment so great, that outpatient or other levels of residential care would not be feasible or effective. Programs must provide~~, at a minimum, daily skilled treatment services seven days a~~ 20 or more hours of skilled treatment services per week according to each client's specific treatment schedule, as directed by the individual treatment plan.

(7) For ASAM level 3.5 clinically managed high-intensity residential clients, services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour staffing coverage and provide~~, at a minimum, daily skilled treatment services seven days a~~ 20 or more hours of skilled treatment services per week according to each client's specific treatment schedule, as directed by the individual treatment plan.

(8) For ASAM level withdrawal management 3.2 clinically managed clients, withdrawal management must be provided according to chapter 245F.

(9) For ASAM level withdrawal management 3.7 medically monitored clients, withdrawal management must be provided according to chapter 245F.

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

Sec. 35. Minnesota Statutes 2023 Supplement, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 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~~, and provide only ASAM 3.7 medically monitored inpatient level of care are not required to enroll as demonstration project providers ~~and meet the requirements of subdivision 3 by January 1, 2025~~. Programs meeting these criteria must submit evidence of providing the required level of care to the commissioner to be exempt from enrolling in the demonstration.

(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.

(e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(f) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with Tribal Nations to discuss participation in the substance use disorder demonstration project.

(g) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

(1) the provider attests that during the time period for which the provider is seeking the rate enhancement, the provider took meaningful steps in their plan approved by the commissioner to meet the demonstration project requirements in subdivision 3; and

(2) the provider submits attestation and evidence, including all information requested by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in a format required by the commissioner.

(h) The commissioner may recoup any rate enhancements paid under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

Sec. 36. Minnesota Statutes 2022, section 256B.0759, subdivision 4, is amended to read:

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care. Providers that have enrolled in the demonstration project but have not met the provider standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under this subdivision until the date that the provider meets the provider standards in subdivision 3. Services provided from July 1, 2022, to the date that the provider meets the provider standards under subdivision 3 shall be reimbursed at rates according to section 254B.05, subdivision 5, paragraph (b). Rate increases paid under this subdivision to a provider for services provided between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider is taking meaningful steps to meet demonstration project requirements that are not otherwise required by law, and the provider provides documentation to the commissioner, upon request, of the steps being taken.

(b) The commissioner may temporarily suspend payments to the provider according to section 256B.04, subdivision 21, paragraph (d), if the provider does not meet the requirements in paragraph (a). Payments withheld from the provider must be made once the commissioner determines that the requirements in paragraph (a) are met.

~~(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), provided on or after July 1, 2020, payment rates must be increased by 25 percent over the rates in effect on December 31, 2019.~~

~~(d)~~ (c) For outpatient individual and group substance use disorder services under section 254B.05, subdivision 5, paragraph (b), ~~clauses~~ clause (1), ~~(6), and (7),~~ and adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on or after January 1, 2021, payment rates must be increased by 20 percent over the rates in effect on December 31, 2020.

~~(e)~~ (d) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the criteria described in paragraph (a) who are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in ~~paragraphs~~ paragraph (c) ~~and (d)~~. The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

~~(f)~~ (e) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph ~~(e)~~ (d) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph ~~(e)~~ (d) is not received, and capitation rates are adjusted as a result. Payment recoveries must not exceed the amount equal to any decrease in rates that results from this provision.

(f) For substance use disorder services with medications for opioid use disorder under section 254B.05, subdivision 5, clause (7), provided on or after January 1, 2021, payment rates must be increased by 20 percent over the rates in effect on December 31, 2020. Upon implementation of new rates according to section 254B.121, the 20 percent increase will no longer apply.

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

Sec. 23. Laws 2021, First Special Session chapter 7, article 11, section 38, as amended by Laws 2022, chapter 98, article 4, section 50, is amended to read:

Sec. 38. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT PAPERWORK REDUCTION.**

(a) The commissioner of human services, in consultation with counties, tribes, managed care organizations, substance use disorder treatment professional associations, and other relevant stakeholders, shall develop, assess, and recommend systems improvements to minimize regulatory paperwork and improve systems for substance use disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes, chapters 245F and 245G, and Minnesota Rules, chapters 2960 and 9530. The commissioner

of human services shall make available any resources needed from other divisions within the department to implement systems improvements.

(b) The commissioner of health shall make available needed information and resources from the Division of Health Policy.

(c) The Office of MN.IT Services shall provide advance consultation and implementation of the changes needed in data systems.

(d) The commissioner of human services shall contract with a vendor that has experience with developing statewide system changes for multiple states at the payer and provider levels. If the commissioner, after exercising reasonable diligence, is unable to secure a vendor with the requisite qualifications, the commissioner may select the best qualified vendor available. When developing recommendations, the commissioner shall consider input from all stakeholders. The commissioner's recommendations shall maximize benefits for clients and utility for providers, regulatory agencies, and payers.

(e) The commissioner of human services and the contracted vendor shall follow the recommendations from the report issued in response to Laws 2019, First Special Session chapter 9, article 6, section 76.

(f) ~~Within two years of contracting with a qualified vendor according to paragraph (d)~~ By December 15, 2024, the commissioner of human services shall take steps to implement paperwork reductions and systems improvements within the commissioner's authority and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a report that includes recommendations for changes in statutes that would further enhance systems improvements to reduce paperwork. The report shall include a summary of the approaches developed and assessed by the commissioner of human services and stakeholders and the results of any assessments conducted.

Sec. 37. **REPEALER.**

Minnesota Statutes 2022, section 245G.22, subdivisions 4 and 7, are repealed.

ARTICLE 5
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2022, section 246.71, subdivision 3, is amended to read:

Subd. 3. **Patient.** "Patient" means any person who is receiving treatment from or committed to a ~~secure~~ state-operated treatment ~~facility~~ program, including the Minnesota Sex Offender Program.

Sec. 2. Minnesota Statutes 2022, section 246.71, subdivision 4, is amended to read:

Subd. 4. **Employee of a ~~secure treatment facility~~ state-operated treatment program or employee.** "Employee of a ~~secure treatment facility~~ state-operated treatment program" or "employee" means an employee of ~~the Minnesota Security Hospital or a secure treatment facility operated by the Minnesota Sex Offender Program~~ any state-operated treatment program.

Sec. 3. Minnesota Statutes 2022, section 246.71, subdivision 5, is amended to read:

Subd. 5. **~~Secure treatment facility~~ State-operated treatment program.** "~~Secure treatment facility~~ State-operated treatment program" means ~~the Minnesota Security Hospital and the Minnesota Sex Offender Program facility in Moose Lake and any portion of the Minnesota Sex Offender Program operated by the Minnesota Sex Offender Program at the Minnesota Security Hospital~~ any state-operated treatment program under the jurisdiction of the executive board, including the Minnesota Sex Offender Program, community behavioral health hospitals, crisis centers, residential facilities, outpatient services, and other community-based services under the executive board's control.

Sec. 4. Minnesota Statutes 2022, section 246.711, is amended to read:

246.711 CONDITIONS FOR APPLICABILITY OF PROCEDURES.

Subdivision 1. **Request for procedures.** An employee of a ~~secure treatment facility~~ state-operated treatment program may request that the procedures of sections 246.71 to 246.722 be followed when the employee may have experienced a significant exposure to a patient.

Subd. 2. **Conditions.** The ~~secure treatment facility~~ state-operated treatment program shall follow the procedures in sections 246.71 to 246.722 when all of the following conditions are met:

(1) a licensed physician, advanced practice registered nurse, or physician assistant determines that a significant exposure has occurred following the protocol under section 246.721;

(2) the licensed physician, advanced practice registered nurse, or physician assistant for the employee needs the patient's blood-borne pathogens test results to begin, continue, modify, or discontinue treatment in accordance with the most current guidelines of the United States Public Health Service, because of possible exposure to a blood-borne pathogen; and

(3) the employee consents to providing a blood sample for testing for a blood-borne pathogen.

Sec. 5. Minnesota Statutes 2022, section 246.712, subdivision 1, is amended to read:

Subdivision 1. **Information to patient.** (a) Before seeking any consent required by the procedures under sections 246.71 to 246.722, a ~~secure treatment facility~~ state-operated treatment program shall inform the patient that the patient's blood-borne pathogen test results, without the patient's name or other uniquely identifying information, shall be reported to the employee if requested and that test results collected under sections 246.71 to 246.722 are for medical purposes as set forth in section 246.718 and may not be used as evidence in any criminal proceedings or civil proceedings, except for procedures under sections 144.4171 to 144.4186.

(b) The ~~secure treatment facility~~ state-operated treatment program shall inform the patient of the insurance protections in section 72A.20, subdivision 29.

(c) The ~~secure treatment facility~~ state-operated treatment program shall inform the patient that the patient may refuse to provide a blood sample and that the patient's refusal may result in a request for a court order to require the patient to provide a blood sample.

(d) The ~~secure treatment facility~~ state-operated treatment program shall inform the patient that the ~~secure treatment facility~~ state-operated treatment program will advise the employee of a ~~secure treatment facility~~ state-operated treatment program of the confidentiality requirements and penalties before the employee's health care provider discloses any test results.

Sec. 6. Minnesota Statutes 2022, section 246.712, subdivision 2, is amended to read:

Subd. 2. **Information to ~~secure treatment facility~~ state-operated treatment program employee.** (a) Before disclosing any information about the patient, the ~~secure treatment~~

~~facility~~ state-operated treatment program shall inform the employee of a ~~secure treatment facility~~ state-operated treatment program of the confidentiality requirements of section 246.719 and that the person may be subject to penalties for unauthorized release of test results about the patient under section 246.72.

(b) The ~~secure treatment facility~~ state-operated treatment program shall inform the employee of the insurance protections in section 72A.20, subdivision 29.

Sec. 7. Minnesota Statutes 2022, section 246.713, is amended to read:

246.713 DISCLOSURE OF POSITIVE BLOOD-BORNE PATHOGEN TEST RESULTS.

If the conditions of sections 246.711 and 246.712 are met, the ~~secure treatment facility~~ state-operated treatment program shall ask the patient if the patient has ever had a positive test for a blood-borne pathogen. The ~~secure treatment facility~~ state-operated treatment program must attempt to get existing test results under this section before taking any steps to obtain a blood sample or to test for blood-borne pathogens. The ~~secure treatment facility~~ state-operated treatment program shall disclose the patient's blood-borne pathogen test results to the employee without the patient's name or other uniquely identifying information.

Sec. 8. Minnesota Statutes 2022, section 246.714, is amended to read:

246.714 CONSENT PROCEDURES GENERALLY.

(a) For purposes of sections 246.71 to 246.722, whenever the ~~secure treatment facility~~ state-operated treatment program is required to seek consent, the ~~secure treatment facility~~ state-operated treatment program shall obtain consent from a patient or a patient's representative consistent with other law applicable to consent.

(b) Consent is not required if the ~~secure treatment facility~~ state-operated treatment program has made reasonable efforts to obtain the representative's consent and consent cannot be obtained within 24 hours of a significant exposure.

(c) If testing of available blood occurs without consent because the patient is unconscious or unable to provide consent, and a representative cannot be located, the ~~secure treatment facility~~ state-operated treatment program shall provide the information required in section 246.712 to the patient or representative whenever it is possible to do so.

(d) If a patient dies before an opportunity to consent to blood collection or testing under sections 246.71 to 246.722, the ~~secure treatment facility~~ state-operated treatment program

does not need consent of the patient's representative for purposes of sections 246.71 to 246.722.

Sec. 9. Minnesota Statutes 2022, section 246.715, subdivision 1, is amended to read:

Subdivision 1. **Procedures with consent.** If a sample of the patient's blood is available, the ~~secure treatment facility~~ state-operated treatment program shall ensure that blood is tested for blood-borne pathogens with the consent of the patient, provided the conditions in sections 246.711 and 246.712 are met.

Sec. 10. Minnesota Statutes 2022, section 246.715, subdivision 2, is amended to read:

Subd. 2. **Procedures without consent.** If the patient has provided a blood sample, but does not consent to blood-borne pathogens testing, the ~~secure treatment facility~~ state-operated treatment program shall ensure that the blood is tested for blood-borne pathogens if the employee requests the test, provided all of the following criteria are met:

(1) the employee and ~~secure treatment facility~~ state-operated treatment program have documented exposure to blood or body fluids during performance of the employee's work duties;

(2) a licensed physician, advanced practice registered nurse, or physician assistant has determined that a significant exposure has occurred under section 246.711 and has documented that blood-borne pathogen test results are needed for beginning, modifying, continuing, or discontinuing medical treatment for the employee as recommended by the most current guidelines of the United States Public Health Service;

(3) the employee provides a blood sample for testing for blood-borne pathogens as soon as feasible;

(4) the ~~secure treatment facility~~ state-operated treatment program asks the patient to consent to a test for blood-borne pathogens and the patient does not consent;

(5) the ~~secure treatment facility~~ state-operated treatment program has provided the patient and the employee with all of the information required by section 246.712; and

(6) the ~~secure treatment facility~~ state-operated treatment program has informed the employee of the confidentiality requirements of section 246.719 and the penalties for unauthorized release of patient information under section 246.72.

Sec. 11. Minnesota Statutes 2022, section 246.715, subdivision 3, is amended to read:

Subd. 3. **Follow-up.** The ~~secure treatment facility~~ state-operated treatment program shall inform the patient whose blood was tested of the results. The ~~secure treatment facility~~ state-operated treatment program shall inform the employee's health care provider of the patient's test results without the patient's name or other uniquely identifying information.

Sec. 12. Minnesota Statutes 2022, section 246.716, subdivision 1, is amended to read:

Subdivision 1. **Procedures with consent.** (a) If a blood sample is not otherwise available, the ~~secure treatment facility~~ state-operated treatment program shall obtain consent from the patient before collecting a blood sample for testing for blood-borne pathogens. The consent process shall include informing the patient that the patient may refuse to provide a blood sample and that the patient's refusal may result in a request for a court order under subdivision 2 to require the patient to provide a blood sample.

(b) If the patient consents to provide a blood sample, the ~~secure treatment facility~~ state-operated treatment program shall collect a blood sample and ensure that the sample is tested for blood-borne pathogens.

(c) The ~~secure treatment facility~~ state-operated treatment program shall inform the employee's health care provider about the patient's test results without the patient's name or other uniquely identifying information. The ~~secure treatment facility~~ state-operated treatment program shall inform the patient of the test results.

(d) If the patient refuses to provide a blood sample for testing, the ~~secure treatment facility~~ state-operated treatment program shall inform the employee of the patient's refusal.

Sec. 13. Minnesota Statutes 2022, section 246.716, subdivision 2, as amended by Laws 2024, chapter 79, article 2, section 58, is amended to read:

Subd. 2. **Procedures without consent.** (a) A ~~secure treatment facility~~ state-operated treatment program or an employee of a ~~secure treatment facility~~ state-operated treatment program may bring a petition for a court order to require a patient to provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in the district court in the county where the patient is receiving treatment from the ~~secure treatment facility~~ state-operated treatment program. The ~~secure treatment facility~~ state-operated treatment program shall serve the petition on the patient three days before a hearing on the petition. The petition shall include one or more affidavits attesting that:

(1) the ~~secure treatment facility~~ state-operated treatment program followed the procedures in sections 246.71 to 246.722 and attempted to obtain blood-borne pathogen test results according to those sections;

(2) a licensed physician, advanced practice registered nurse, or physician assistant knowledgeable about the most current recommendations of the United States Public Health Service has determined that a significant exposure has occurred to the employee of a ~~secure treatment facility~~ state-operated treatment program under section 246.721; and

(3) a physician, advanced practice registered nurse, or physician assistant has documented that the employee has provided a blood sample and consented to testing for blood-borne pathogens and blood-borne pathogen test results are needed for beginning, continuing, modifying, or discontinuing medical treatment for the employee under section 246.721.

(b) ~~Secure treatment facilities~~ State-operated treatment programs shall cooperate with petitioners in providing any necessary affidavits to the extent that facility staff can attest under oath to the facts in the affidavits.

(c) The court may order the patient to provide a blood sample for blood-borne pathogen testing if:

(1) there is probable cause to believe the employee of a ~~secure treatment facility~~ state-operated treatment program has experienced a significant exposure to the patient;

(2) the court imposes appropriate safeguards against unauthorized disclosure that must specify the persons who have access to the test results and the purposes for which the test results may be used;

(3) a licensed physician, advanced practice registered nurse, or physician assistant for the employee of a ~~secure treatment facility~~ state-operated treatment program needs the test results for beginning, continuing, modifying, or discontinuing medical treatment for the employee; and

(4) the court finds a compelling need for the test results. In assessing compelling need, the court shall weigh the need for the court-ordered blood collection and test results against the interests of the patient, including, but not limited to, privacy, health, safety, or economic interests. The court shall also consider whether involuntary blood collection and testing would serve the public interests.

(d) The court shall conduct the proceeding in camera unless the petitioner or the patient requests a hearing in open court and the court determines that a public hearing is necessary to the public interest and the proper administration of justice.

(e) The patient may arrange for counsel in any proceeding brought under this subdivision.

Sec. 14. Minnesota Statutes 2022, section 246.717, is amended to read:

246.717 NO DISCRIMINATION.

A ~~secure treatment facility~~ state-operated treatment program shall not withhold care or treatment on the requirement that the patient consent to blood-borne pathogen testing under sections 246.71 to 246.722.

Sec. 15. Minnesota Statutes 2022, section 246.721, as amended by Laws 2024, chapter 79, article 2, section 60, is amended to read:

246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.

(a) A ~~secure treatment facility~~ state-operated treatment program shall follow applicable Occupational Safety and Health Administration guidelines under Code of Federal Regulations, title 29, part 1910.1030, for blood-borne pathogens.

(b) Every ~~secure treatment facility~~ state-operated treatment program shall adopt and follow a postexposure protocol for employees at a ~~secure treatment facility~~ state-operated treatment program who have experienced a significant exposure. The postexposure protocol must adhere to the most current recommendations of the United States Public Health Service and include, at a minimum, the following:

(1) a process for employees to report an exposure in a timely fashion;

(2) a process for an infectious disease specialist, or a licensed physician, advanced practice registered nurse, or physician assistant who is knowledgeable about the most current recommendations of the United States Public Health Service in consultation with an infectious disease specialist, (i) to determine whether a significant exposure to one or more blood-borne pathogens has occurred, and (ii) to provide, under the direction of a licensed physician, advanced practice registered nurse, or physician assistant, a recommendation or recommendations for follow-up treatment appropriate to the particular blood-borne pathogen or pathogens for which a significant exposure has been determined;

(3) if there has been a significant exposure, a process to determine whether the patient has a blood-borne pathogen through disclosure of test results, or through blood collection and testing as required by sections 246.71 to 246.722;

(4) a process for providing appropriate counseling prior to and following testing for a blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and

follow-up recommendations according to the most current recommendations of the United States Public Health Service for testing and treatment;

(5) a process for providing appropriate counseling under clause (4) to the employee of a ~~secure treatment facility~~ state-operated treatment program and to the patient; and

(6) compliance with applicable state and federal laws relating to data practices, confidentiality, informed consent, and the patient bill of rights.

Sec. 17. Minnesota Statutes 2022, section 246.722, is amended to read:

246.722 IMMUNITY.

A ~~secure treatment facility~~ state-operated treatment program, licensed physician, advanced practice registered nurse, physician assistant, and designated health care personnel are immune from liability in any civil, administrative, or criminal action relating to the disclosure of test results of a patient to an employee of a ~~secure treatment facility~~ state-operated treatment program and the testing of a blood sample from the patient for blood-borne pathogens if a good faith effort has been made to comply with sections 246.71 to 246.722.

Sec. 18. Laws 2023, chapter 61, article 8, section 13, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The task force shall consist of the following members, appointed as follows:

(1) a member appointed by the governor;

(2) the commissioner of human services, or a designee;

(3) a member representing Department of Human Services direct care and treatment services who has experience with civil commitments, appointed by the commissioner of human services;

(4) the ombudsman for mental health and developmental disabilities;

(5) a hospital representative, appointed by the Minnesota Hospital Association;

(6) a county representative, appointed by the Association of Minnesota Counties;

(7) a county social services representative, appointed by the Minnesota Association of County Social Service Administrators;

(8) a member appointed by the ~~Minnesota Civil Commitment Defense Panel~~ Hennepin County Commitment Defense Project;

(9) a county attorney, appointed by the Minnesota County Attorneys Association;

(10) a county sheriff, appointed by the Minnesota Sheriffs' Association;

(11) a member appointed by the Minnesota Psychiatric Society;

(12) a member appointed by the Minnesota Association of Community Mental Health Programs;

(13) a member appointed by the National Alliance on Mental Illness Minnesota;

(14) the Minnesota Attorney General;

(15) three individuals from organizations representing racial and ethnic groups that are overrepresented in the criminal justice system, appointed by the commissioner of corrections; and

(16) one member of the public with lived experience directly related to the task force's purposes, appointed by the governor.

(b) Appointments must be made no later than July 15, 2023.

(c) Member compensation and reimbursement for expenses are governed by Minnesota Statutes, section 15.059, subdivision 3.

(d) A member of the legislature may not serve as a member of the task force.

ARTICLE 6
MISCELLANEOUS

Section 1. Minnesota Statutes 2022, section 254A.03, subdivision 1, is amended to read:

Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. This section shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

(1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and recovery of persons with substance misuse and substance use disorder;

(2) coordinate and review all activities and programs of all the various state departments as they relate to problems associated with substance misuse and substance use disorder;

(3) develop, demonstrate, and disseminate new methods and techniques for prevention, early intervention, treatment and recovery support for substance misuse and substance use disorder;

(4) gather facts and information about substance misuse and substance use disorder, and about the efficiency and effectiveness of prevention, treatment, and recovery support services from all comprehensive programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The state authority shall disseminate facts and summary information about problems associated with substance misuse and substance use disorder to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and recovery support;

(5) inform and educate the general public on substance misuse and substance use disorder;

(6) serve as the state authority concerning substance misuse and substance use disorder by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor ~~and the legislature~~ containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost;

(7) establish a state plan which shall set forth goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies operating substance misuse or substance use disorder programs or administering state or federal funds for such programs shall annually set their program goals and priorities in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;

(8) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;

(9) receive and administer money available for substance misuse and substance use disorder programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;

(10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source;

(11) with respect to substance misuse and substance use disorder programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in substance misuse and substance use disorder, and understanding of social and cultural problems related to substance misuse and substance use disorder, in the American Indian community.

Sec. 2. Minnesota Statutes 2023 Supplement, section 256B.4914, subdivision 10, is amended to read:

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

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

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

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

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

(1) values for transportation rates;

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

(3) values for indirect services;

(4) values for nursing;

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

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

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

(8) direct care workforce labor market measures;

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

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

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

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

~~(d)~~ (c) 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.

Sec. 3. Minnesota Statutes 2023 Supplement, 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 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in subdivision 17, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

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

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

(e) The commissioner shall use data collected in paragraph (a) to determine the compliance with requirements identified under subdivision 10d. The commissioner shall identify providers who have not met the thresholds identified under subdivision 10d on the

Department of Human Services website for the year for which the providers reported their costs.

Sec. 4. Minnesota Statutes 2022, section 256B.69, subdivision 5k, is amended to read:

Subd. 5k. **Actuarial soundness.** ~~(a)~~ Rates paid to managed care plans and county-based purchasing plans shall satisfy requirements for actuarial soundness. In order to comply with this subdivision, the rates must:

(1) be neither inadequate nor excessive;

(2) satisfy federal requirements;

(3) in the case of contracts with incentive arrangements, not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement;

(4) be developed in accordance with generally accepted actuarial principles and practices;

(5) be appropriate for the populations to be covered and the services to be furnished under the contract; and

(6) be certified as meeting the requirements of federal regulations by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

~~(b) Each year within 30 days of the establishment of plan rates the commissioner shall report to the chairs and ranking minority members of the senate Health and Human Services Budget Division and the house of representatives Health Care and Human Services Finance Division to certify how each of these conditions have been met by the new payment rates.~~

Sec. 5. Minnesota Statutes 2022, section 402A.16, subdivision 2, is amended to read:

Subd. 2. **Duties.** The Human Services Performance Council shall:

(1) hold meetings at least quarterly that are in compliance with Minnesota's Open Meeting Law under chapter 13D;

(2) annually review the annual performance data submitted by counties or service delivery authorities;

(3) review and advise the commissioner on department procedures related to the implementation of the performance management system and system process requirements and on barriers to process improvement in human services delivery;

(4) advise the commissioner on the training and technical assistance needs of county or service delivery authority and department personnel;

(5) review instances in which a county or service delivery authority has not made adequate progress on a performance improvement plan and make recommendations to the commissioner under section 402A.18;

(6) consider appeals from counties or service delivery authorities that are in the remedies process and make recommendations to the commissioner on resolving the issue;

(7) convene working groups to update and develop outcomes, measures, and performance thresholds for the performance management system and, on an annual basis, present these recommendations to the commissioner, including recommendations on when a particular essential human services program has a balanced set of program measures in place;

(8) make recommendations on human services administrative rules or statutes that could be repealed in order to improve service delivery; and

(9) provide information to stakeholders on the council's role and regularly collect stakeholder input on performance management system performance~~; and~~.

~~(10) submit an annual report to the legislature and the commissioner, which includes a comprehensive report on the performance of individual counties or service delivery authorities as it relates to system measures; a list of counties or service delivery authorities that have been required to create performance improvement plans and the areas identified for improvement as part of the remedies process; a summary of performance improvement training and technical assistance activities offered to the county personnel by the department; recommendations on administrative rules or state statutes that could be repealed in order to improve service delivery; recommendations for system improvements, including updates to system outcomes, measures, and thresholds; and a response from the commissioner.~~

Sec. 6. **REPEALER.**

Minnesota Statutes 2022, sections 245G.011, subdivision 5; 252.34; and 256.01, subdivision 39, are repealed.

245G.011 BEHAVIORAL HEALTH CRISIS FACILITIES GRANTS.

Subd. 5. **Report.** The commissioner shall report to the legislative committees with jurisdiction over mental health issues and capital investment. The report is due by February 15 of each odd-numbered year and must include information on the projects funded and the programs and services provided in those facilities.

245G.22 OPIOID TREATMENT PROGRAMS.

Subd. 4. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 6, paragraph (a), that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing practitioner. The meeting must occur before the administration or dispensing of the increased medication dose.

Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a medical director or prescribing practitioner assesses and determines that a client meets the criteria in subdivision 6 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in this subdivision must be followed when the medication to be dispensed is methadone hydrochloride. The results of the assessment must be contained in the client file. The number of unsupervised use medication doses per week in paragraphs (b) to (d) is in addition to the number of unsupervised use medication doses a client may receive for days the clinic is closed for business as allowed by subdivision 6, paragraph (a).

(b) During the first 90 days of treatment, the unsupervised use medication supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the unsupervised use medication supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the unsupervised use medication supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day unsupervised use medication supply.

(f) After one year of continuous treatment, a client may be given a maximum two-week unsupervised use medication supply.

(g) After two years of continuous treatment, a client may be given a maximum one-month unsupervised use medication supply, but must make monthly visits to the program.

252.34 REPORT BY COMMISSIONER OF HUMAN SERVICES.

Beginning January 1, 2013, the commissioner of human services shall provide a biennial report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and funding. The report must provide a summary of overarching goals and priorities for persons with disabilities, including the status of how each of the following programs administered by the commissioner is supporting the overarching goals and priorities:

(1) home and community-based services waivers for persons with disabilities under sections 256B.092 and 256B.49;

(2) home care services under section 256B.0652; and

(3) other relevant programs and services as determined by the commissioner.

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 39. **Dedicated funds report.** By October 1, 2014, and with each February forecast thereafter, the commissioner of human services must provide to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services finance a report of all dedicated funds and accounts. The report must include the name of the dedicated fund or account; a description of its purpose, and the legal citation for its creation; the beginning balance, projected receipts, and expenditures; and the ending balance for each fund and account.

256.975 MINNESOTA BOARD ON AGING.

Subd. 7f. **Exemptions from long-term care options counseling for assisted living.** Individuals shall be exempt from the requirements outlined in subdivision 7e in the following circumstances:

(1) the individual is seeking a lease-only arrangement in a subsidized housing setting;

(2) the individual has previously received a long-term care consultation assessment under section 256B.0911. In this instance, the assessor who completes the long-term care consultation assessment will issue a verification code and provide it to the individual;

(3) the individual is receiving or is being evaluated for hospice services from a hospice provider licensed under sections 144A.75 to 144A.755; or

(4) the individual has used financial planning services and created a long-term care plan as defined by the commissioner in the 12 months prior to signing a lease or contract with a licensed assisted living facility.

Subd. 7g. **Long-term care options counseling at hospital discharge.** (a) Hospitals shall refer all individuals described in paragraph (b) prior to discharge from an inpatient hospital stay to the Senior LinkAge Line for long-term care options counseling. Hospitals shall make these referrals using referral protocols and processes developed under subdivision 7. The purpose of the counseling is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive setting.

(b) The individuals who shall be referred under paragraph (a) include older adults who are at risk of nursing home placement. Protocols for identifying at-risk individuals shall be developed under subdivision 7, paragraph (b), clause (12).

(c) Counseling provided under this subdivision shall meet the requirements for the consultation required under subdivision 7e.

256R.18 REPORT BY COMMISSIONER OF HUMAN SERVICES.

(a) Beginning January 1, 2019, the commissioner shall provide to the house of representatives and senate committees with jurisdiction over nursing facility payment rates a biennial report on the effectiveness of the reimbursement system in improving quality, restraining costs, and any other features of the system as determined by the commissioner.

(b) This section expires January 1, 2026.