State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2434

03/17/2025 Authored by Schomacker and Noor
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

A bill for an act

relating to human services; modifying provisions relating to aging and older adult services, disability services, early intensive developmental and behavioral intervention, direct care and treatment, and health care; establishing a patient driven payment model phase-in, the Minnesota Caregiver Defined Contribution Retirement Fund Trust, recovery residence certification, and a working group; requiring stipend payments to certain collective bargaining unit members; requiring reports; appropriating money; amending Minnesota Statutes 2024, sections 13.46, subdivision 1; 144.0724, subdivision 11; 144A.071, subdivisions 4a, 4c, 4d; 144A.161, subdivision 10; 179A.54, by adding a subdivision; 245.4661, subdivisions 2, 6, 7; 245.91, subdivision 4; 245C.16, subdivision 1; 245G.01, subdivision 13b, by adding subdivisions; 245G.02, subdivision 2; 245G.07, subdivisions 1, 3, 4, by adding subdivisions; 245G.11, subdivisions 6, 7, by adding a subdivision; 245G.22, subdivisions 11, 15; 246B.10; 254A.19, subdivision 4; 254B.01, subdivisions 10, 11; 254B.02, subdivision 5; 254B.03, subdivisions 1, 3, 4; 254B.04, subdivisions 1a, 5, 6, 6a; 254B.05, subdivisions 1, 1a; 254B.06, subdivision 2; 254B.09, subdivision 2; 254B.181, subdivisions 1, 2, 3, by adding subdivisions; 254B.19, subdivision 1; 256.01, subdivisions 29, 34; 256.043, subdivision 3; 256.9657, subdivision 1; 256B.04, subdivisions 12, 14; 256B.0625, subdivisions 5m, 17, by adding a subdivision; 256B.0659, subdivision 17a; 256B.0757, subdivision 4c; 256B.0924, subdivision 6; 256B.0949, subdivisions 15, 16, by adding a subdivision; 256B.19, subdivision 1; 256B.431, subdivision 30; 256B.49, by adding a subdivision; 256B.4914, subdivisions 3, 5, 5a, 5b, 6a, 7a, 7b, 7c, 8, 9, by adding subdivisions; 256B.85, subdivisions 7a, 8, 16; 256B.851, subdivisions 5, 6; 256G.01, subdivision 3; 256G.08, subdivisions 1, 2; 256G.09, subdivisions 1, 2; 256I.04, subdivision 2a; 256R.02, subdivisions 18, 19, 22, by adding subdivisions; 256R.10, subdivision 8; 256R.23, subdivisions 7, 8; 256R.24, subdivision 3; 256R.25; 256R.26, subdivision 9; 256R.43; 260E.14, subdivision 1; 325F.725; 611.43, by adding a subdivision; 611.46, subdivision 1; 611.55, by adding a subdivision; 626.5572, subdivision 13; proposing coding for new law in Minnesota Statutes, chapters 245A; 254B; 256R; repealing Minnesota Statutes 2024, sections 144A.1888; 245G.01, subdivision 20d; 245G.07, subdivision 2; 254B.01, subdivision 5; 254B.04, subdivision 2a; 256B.0625, subdivisions 18b, 18e, 18h; 256B.434, subdivision 4; 256R.02, subdivision 38; 256R.12, subdivision 10; 256R.23, subdivision 6; 256R.36; 256R.40; 256R.41; 256R.481; 256R.53, subdivision 1.

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

ARTICLE 1
AGING AND OLDER ADULT SERVICES

Section 1. Minnesota Statutes 2024, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling,

or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434 or chapter 256R;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental

per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment

provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256R.26. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256R.50;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically

assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

~~(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256R.40;~~

~~(ff)~~ (ee) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;

~~(gg)~~ (ff) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

~~(hh)~~ (gg) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080; or

~~(ii)~~ (hh) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the

name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

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

Sec. 2. Minnesota Statutes 2024, section 144A.071, subdivision 4c, is amended to read:

Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(1) to license and certify an 80-bed city-owned facility in Nicollet County to be constructed on the site of a new city-owned hospital to replace an existing 85-bed facility attached to a hospital that is also being replaced. The threshold allowed for this project under section 144A.073 shall be the maximum amount available to pay the additional medical assistance costs of the new facility;

(2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis County, provided that the 29 beds must be transferred from active or layaway status at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment rate at that facility shall not be adjusted as a result of this transfer. The operating payment rate of the facility adding beds after completion of this project shall be the same as it was on the day prior to the day the beds are licensed and certified. This project shall not proceed unless it is approved and financed under the provisions of section 144A.073;

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be

reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias;

~~(4) to license and certify up to 80 beds transferred from an existing state-owned nursing facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be determined based on the interim and settle-up payment provisions of section 256R.27 and the reimbursement provisions of chapter 256R. The property payment rate for the first three years of operation shall be $35 per day. For subsequent years, the property payment rate of $35 per day shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434;~~

~~(5)~~ (4) to initiate a pilot program to license and certify up to 80 beds transferred from an existing county-owned nursing facility in Steele County relocated to the site of a new acute care facility as part of the county's Communities for a Lifetime comprehensive plan to create innovative responses to the aging of its population. Upon relocation to the new site, the nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days; and

~~(6)~~ (5) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a

communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of its population. Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding the carryforward of the approval authority in section 144A.073, subdivision 11, the funding approved in April 2009 by the commissioner of health for a project in Goodhue County shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure rate adjustment under Minnesota Statutes 2024, section 256R.40. The construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f. The payment rate for external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (vi):

(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) multiply the amount in item (iv) by 57.2 percent; and

(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

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

Sec. 3. Minnesota Statutes 2024, section 144A.071, subdivision 4d, is amended to read:

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and Minnesota Statutes 2024, section 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under Minnesota Statutes 2024, section 256R.40, subdivision 5;

(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and

(3) the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan and the complete closure of the facility or facilities designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under housing support under chapter 256I;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under Minnesota Statutes 2024, section 256R.40; and

(7) the savings from not paying external fixed costs payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the external fixed costs payment rate adjustment under this subdivision, the closing facilities shall:

(1) submit an application for closure according to Minnesota Statutes 2024, section 256R.40, subdivision 2; and

(2) follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

(g) Projects approved on or after March 1, 2020, are not subject to paragraph (a), clauses (2) and (3), and paragraph (c). The 65 percent projected net cost savings to the state calculated

in paragraph (b) must be applied to the moratorium cost of the project and the remainder must be added to the moratorium funding under section 144A.073, subdivision 11.

(h) Consolidation project applications not approved by the commissioner prior to March 1, 2020, are subject to the moratorium process under section 144A.073, subdivision 2. Upon request by the applicant, the commissioner may extend this deadline to August 1, 2020, so long as the facilities, bed numbers, and counties specified in the original application are not altered. Proposals from facilities seeking approval for a consolidation project prior to March 1, 2020, must be received by the commissioner no later than January 1, 2020. This paragraph expires August 1, 2020.

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

Sec. 4. Minnesota Statutes 2024, section 144A.161, subdivision 10, is amended to read:

Subd. 10. **Facility closure rate adjustment.** Upon the request of a closing facility, the commissioner of human services must allow the facility a closure rate adjustment equal to a 50 percent payment rate increase to reimburse relocation costs or other costs related to facility closure. This rate increase is effective on the date the facility's occupancy decreases to 90 percent of capacity days after the written notice of closure is distributed under subdivision 5 and shall remain in effect for a period of up to 60 days. ~~The commissioner shall delay the implementation of rate adjustments under section 256R.40, subdivisions 5 and 6, to offset the cost of this rate adjustment.~~

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

Sec. 5. Minnesota Statutes 2024, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. ~~Beds on layaway status continue to be subject to the surcharge.~~ The commissioner of human services must

acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

~~(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.~~

~~(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.~~

~~(d)~~ (b) Effective July 15, 2003, the surcharge under ~~paragraph (c)~~ this subdivision shall be increased to $2,815.

~~(e)~~ (c) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph ~~(d)~~ (b) based on the commissioner's determination of a permissible surcharge.

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

Sec. 6. Minnesota Statutes 2024, section 256B.431, subdivision 30, is amended to read:

Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. ~~At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11.~~ The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain ~~or change~~ the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 or chapter 256R completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in Minnesota Statutes 2024, section 256B.434, subdivision 4~~, paragraph (c)~~. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under that section or chapter that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain ~~or change~~ the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in Minnesota Statutes 2024, section 256B.434, subdivision 4~~, paragraph (c)~~. The property payment rate increase shall be effective the first day of the month of January or July, whichever occurs first following the date on which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section, section 256B.434, or chapter 256R, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section 256R.06, subdivision 5.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

(i) The commissioner must not increase the property payment rates under this subdivision for beds placed in or removed from layaway on or after July 1, 2025.

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

Sec. 7. Minnesota Statutes 2024, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means:

(1) premium expenses for group coverage;

(2) actual expenses incurred for self-insured plans, including actual claims paid, stop-loss premiums, and plan fees. Actual expenses incurred for self-insured plans does not include allowances for future funding unless the plan meets the ~~Medicare~~ provider reimbursement manual requirements for reporting on a premium basis when the ~~Medicare~~ provider reimbursement manual regulations define the actual costs; and

(3) employer contributions to employer-sponsored individual coverage health reimbursement arrangements as provided by Code of Federal Regulations, title 45, section 146.123, employee health reimbursement accounts, and health savings accounts.

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

Sec. 8. Minnesota Statutes 2024, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; ~~planned closure rate adjustments under section 256R.40;~~ consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; ~~single-bed room incentives under section 256R.41;~~ property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; and Public Employees Retirement Association employer costs~~; and border city rate adjustments under section 256R.481~~.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 9. Minnesota Statutes 2024, section 256R.02, subdivision 22, is amended to read:

Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life~~,~~; dental~~,~~; workers' compensation~~,~~; short- and long-term disability~~,~~; long-term care insurance~~,~~; accident insurance~~,~~; supplemental insurance~~,~~; legal assistance insurance~~,~~; profit sharing~~,~~; child care costs~~,~~; health insurance costs not covered under subdivision 18, including costs associated with eligible part-time employee family members or retirees~~,~~; and pension and retirement plan contributions, except for the Public Employees Retirement Association costs.

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

Sec. 10. Minnesota Statutes 2024, section 256R.02, is amended by adding a subdivision to read:

Subd. 36a. **Patient driven payment model or PDPM.** "Patient driven payment model" or "PDPM" has the meaning given in section 144.0724, subdivision 2.

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

Sec. 11. Minnesota Statutes 2024, section 256R.02, is amended by adding a subdivision to read:

Subd. 45a. **Resource utilization group or RUG.** "Resource utilization group" or "RUG" has the meaning given in section 144.0724, subdivision 2.

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

Sec. 12. Minnesota Statutes 2024, section 256R.10, subdivision 8, is amended to read:

Subd. 8. **Employer health insurance costs.** (a) Employer health insurance costs are allowable for (1) all nursing facility employees, and (2) the spouse and dependents of those employees who are employed on average at least 30 hours per week.

(b) Effective for the rate year beginning on January 1, 2026, the annual reimbursement cap for health insurance costs is $14,703, as adjusted according to paragraph (c). The allowable costs for health insurance must not exceed the reimbursement cap multiplied by the annual average month end number of allowed enrolled nursing facility employees from the applicable cost report period. For shared employees, the allowable number of enrolled employees includes only the nursing facility percentage of any shared allowed enrolled employees. The allowable number of enrolled employees must not include non-nursing facility employees or individuals who elect COBRA continuation coverage.

(c) Effective for rate years beginning on or after January 1, 2026, the commissioner shall adjust the annual reimbursement cap for employer health insurance costs by the previous year's cap plus an inflation adjustment. The commissioner must index for the inflation based on the change in the Consumer Price Index (all items-urban) (CPI-U) forecasted by the Reports and Forecast Division of the Department of Human Services in the fourth quarter of the calendar year preceding the rate year. The commissioner must base the inflation adjustment on the 12-month period from the second quarter of the previous cost report year to the second quarter of the cost report year for which the cap is being applied.

~~(b)~~ (d) The commissioner must not treat employer contributions to employer-sponsored individual coverage health reimbursement arrangements as allowable costs if the facility does not provide the commissioner copies of the employer-sponsored individual coverage health reimbursement arrangement plan documents and documentation of any health insurance premiums and associated co-payments reimbursed under the arrangement. Documentation of reimbursements must denote any reimbursements for health insurance premiums or associated co-payments incurred by the spouses or dependents of nursing facility employees who work on average less than 30 hours per week.

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

Sec. 13. Minnesota Statutes 2024, section 256R.23, subdivision 7, is amended to read:

Subd. 7. **Determination of direct care payment rates.** A facility's direct care payment rate equals the lesser of (1) the facility's direct care costs per standardized day, ~~or~~ (2) the facility's direct care costs per standardized day divided by its cost to limit ratio, or (3) 102 percent of the previous year's other care-related payment rate.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 14. Minnesota Statutes 2024, section 256R.23, subdivision 8, is amended to read:

Subd. 8. **Determination of other care-related payment rates.** A facility's other care-related payment rate equals the lesser of (1) the facility's other care-related cost per resident day, ~~or~~ (2) the facility's other care-related cost per resident day divided by its cost to limit ratio, or (3) 102 percent of the previous year's other care-related payment rate.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 15. Minnesota Statutes 2024, section 256R.24, subdivision 3, is amended to read:

Subd. 3. **Determination of the other operating payment rate.** A facility's other operating payment rate equals 105 percent of the median other operating cost per day or 102 percent of the previous year's other operating payment rate.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 16. Minnesota Statutes 2024, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

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

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

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

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

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

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

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

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

~~(i)~~ (g) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the allowable amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 17. Minnesota Statutes 2024, section 256R.26, subdivision 9, is amended to read:

Subd. 9. **Transition period.** (a) A facility's property payment rate is the property rate established for the facility under sections 256B.431 and 256B.434 until the facility's property rate is transitioned upon completion of any project authorized under section 144A.071, subdivision 3 or 4d; or 144A.073, subdivision 3, to the fair rental value property rate calculated under this chapter.

(b) Effective the first day of the first month of the calendar quarter after the completion of the project described in paragraph (a), the commissioner shall transition a facility to the property payment rate calculated under this chapter. The initial rate year ends on December 31 and may be less than a full 12-month period. The commissioner shall schedule an appraisal within 90 days of the commissioner receiving notification from the facility that the project is completed. The commissioner shall apply the property payment rate determined after the appraisal retroactively to the first day of the first month of the calendar quarter after the completion of the project.

(c) Upon a facility's transition to the fair rental value property rates calculated under this chapter, the facility's total property payment rate under subdivision 8 shall be the only payment for costs related to capital assets, including depreciation, interest and lease expenses for all depreciable assets, including movable equipment, land improvements, and land. Facilities with property payment rates established under subdivisions 1 to 8 are not eligible for planned closure rate adjustments under Minnesota Statutes 2024, section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under Minnesota Statutes 2024, section 256R.41; and the property rate inflation adjustment under Minnesota Statutes 2024, section 256B.434, subdivision 4. The commissioner shall remove any of these incentives from the facility's existing rate upon the facility transitioning to the fair rental value property rates calculated under this chapter.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 18. Minnesota Statutes 2024, section 256R.43, is amended to read:

256R.43 BED HOLDS.

The commissioner shall limit payment for leave days in a nursing facility to 30 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules, part 9505.0415. For

the purpose of establishing leave day payments, the commissioner shall determine occupancy based on the number of licensed and certified beds in the facility that are not in layaway status.

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

Sec. 19. **[256R.531] PATIENT DRIVEN PAYMENT MODEL PHASE-IN.**

Subdivision 1. **Model phase-in.** From October 1, 2025, to December 31, 2028, the commissioner shall determine an adjustment to the total payment rate for each facility as determined under sections 256R.21 and 256R.27 to phase in the direct care payment rate from the RUG-IV case mix classification system to the patient driven payment model (PDPM) case mix classification system.

Subd. 2. **RUG-IV standardized days and facility case mix index.** (a) The commissioner must determine the RUG-IV standardized days and facility average case mix using the sum of the resident days by case mix classification for all payers on the Minnesota Statistical and Cost Report.

(b) For the rate year beginning January 1, 2028, to December 31, 2028:

(1) the commissioner must determine the RUG-IV facility average case mix using the sum of the resident days by the case mix classification for all payers on the September 30, 2025, Minnesota Statistical and Cost Report; and

(2) the commissioner must determine the RUG-IV standardized days by multiplying the resident days on the September 30, 2026, Minnesota Statistical and Cost Report by the RUG-IV facility case mix index determined under clause (1).

Subd. 3. **RUG-IV medical assistance case mix adjusted direct care payment rate.** The commissioner must determine a facility's RUG-IV blended medical assistance case mix adjusted direct care payment rate as the product of:

(1) the facility's RUG-IV direct care and payment rate determined in section 256R.23, subdivision 7, using the RUG-IV standardized days determined in subdivision 2; and

(2) the corresponding medical assistance facility average case mix index for medical assistance days determined in subdivision 2.

Subd. 4. **PDPM medical assistance case mix adjusted direct care payment rate.** The commissioner must determine a facility's PDPM medical assistance case mix adjusted direct care payment rate as the product of:

(1) the facility's direct care payment rate determined in section 256R.23, subdivision 7; and

(2) the corresponding medical assistance facility average case mix index for medical assistance days as defined in section 256R.02, subdivision 20.

Subd. 5. **Blended medical assistance case mix adjusted direct care payment rate.** The commissioner must determine a facility's blended medical assistance case mix adjusted direct care payment rate as the sum of:

(1) the RUG-IV medical assistance case mix adjusted direct care payment rate determined in subdivision 3 multiplied by the following percentages:

(i) from October 1, 2025, to December 31, 2026, 75 percent;

(ii) from January 1, 2027, to December 31, 2027, 50 percent; and

(iii) from January 1, 2028, to December 31, 2028, 25 percent; and

(2) the PDPM medical assistance case mix adjusted direct care payment rate determined in subdivision 4 multiplied by the following percentages:

(i) October 1, 2025, to December 31, 2026, 25 percent;

(ii) January 1, 2027, to December 31, 2027, 50 percent; and

(iii) January 1, 2028, to December 31, 2028, 75 percent.

Subd. 6. **PDPM phase-in rate adjustment.** The commissioner shall determine a facility's PDPM phase-in rate adjustment as the difference between:

(1) the blended medical assistance case mix adjusted direct care payment rate determined in subdivision 5; and

(2) the PDPM medical assistance case mix adjusted direct care payment rate determined in section 256R.23, subdivision 7.

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

Sec. 20. **[256R.532] NURSING FACILITY RATE ADD-ON FOR WORKFORCE STANDARDS.**

(a) Effective for rate years beginning on and after January 1, 2028, or upon federal approval, whichever is later, the commissioner shall annually provide a rate add-on amount for nursing facilities reimbursed under this chapter for the initial standards for wages for nursing home workers adopted by the Nursing Home Workforce Standards Board in

Minnesota Rules, parts 5200.2060 to 5200.2090, pursuant to section 181.213, subdivision 2, paragraph (c). The add-on amount is equal to:

(1) $3.97 per resident day, effective January 1, 2028; and

(2) $8.62 per resident day, effective January 1, 2029.

(b) Effective upon federal approval, the commissioner must determine the add-on amount for subsequent rate years in consultation with the commissioner of labor and industry.

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

Sec. 21. **REPEALER.**

(a) Minnesota Statutes 2024, sections 256B.434, subdivision 4; 256R.02, subdivision 38; 256R.40; 256R.41; 256R.481; and 256R.53, subdivision 1, are repealed.

(b) Minnesota Statutes 2024, sections 144A.1888; 256R.12, subdivision 10; and 256R.36, are repealed.

(c) Minnesota Statutes 2024, section 256R.23, subdivision 6, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2026. Paragraph (b) is effective the day following final enactment. Paragraph (c) is effective October 1, 2025.

ARTICLE 2
DISABILITY SERVICES

Section 1. Minnesota Statutes 2024, section 179A.54, is amended by adding a subdivision to read:

Subd. 12. **Minnesota Caregiver Defined Contribution Retirement Fund Trust.** (a) The state and an exclusive representative certified pursuant to this section may establish a joint labor and management trust, referred to as the Minnesota Caregiver Defined Contribution Retirement Fund Trust, for the exclusive purpose of creating, implementing, and administering a retirement plan for individual providers of direct support services who are represented by the exclusive representative.

(b) The state must make financial contributions to the Minnesota Caregiver Defined Contribution Retirement Fund Trust pursuant to a collective bargaining agreement negotiated under this section. The financial contributions by the state must be held in trust for the purpose of paying, from principal, income, or both, the costs associated with creating, implementing, and administering a defined contribution retirement plan for individual providers of direct support services working under a collective bargaining agreement and

providing services through a covered program under section 256B.0711. A board of trustees composed of an equal number of trustees appointed by the governor and trustees appointed by the exclusive representative under this section must administer, manage, and otherwise jointly control the Minnesota Caregiver Defined Contribution Retirement Fund Trust. The trust must not be an agent of either the state or the exclusive representative.

(c) A third-party administrator, financial management institution, other appropriate entity, or any combination thereof may provide trust administrative, management, legal, and financial services to the board of trustees as designated by the board of trustees from time to time. The services must be paid from the money held in trust and created by the state's financial contributions to the Minnesota Caregiver Defined Contribution Retirement Fund Trust.

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

(e) Financial contributions to or participation in the management or administration of the Minnesota Caregiver Defined Contribution Retirement Fund Trust must not be considered an unfair labor practice under section 179A.13, or a violation of Minnesota law.

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

Sec. 2. **[245A.142] EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION PROVISIONAL LICENSURE.**

Subdivision 1. **Regulatory powers.** The commissioner shall regulate early intensive developmental and behavioral intervention (EIDBI) agencies pursuant to this section.

Subd. 2. **Provisional license.** (a) The commissioner shall issue a provisional license to an agency providing EIDBI services as described in section 256B.0949 that meet the requirements of this section by .... A provisional license is effective for up to one year from the initial effective date of the license, except that a provisional license may be extended according to subdivisions ..., paragraph (b), and 3.

(b) Beginning ...., no agency providing EIDBI services may operate in Minnesota unless licensed under this section.

Subd. 3. **Provisional license regulatory functions.** The commissioner may:

(1) license, survey, and monitor without advance notice in accordance with this section;

(2) investigate reports of maltreatment;

(3) investigate complaints against EIDBI agencies;

(4) issue correction orders and assess monetary penalties; and

(5) take other action reasonably required to accomplish the purposes of this section.

Subd. 4. **Provisional license requirements.** (a) A provisional license holder must:

(1) identify all controlling individuals, as defined in section 245A.02, subdivision 5a, for the agency;

(2) provide documented disclosures surrounding the use of billing agencies or other consultants, available to the department upon request;

(3) establish provider policies and procedures related to staff training, staff qualifications, quality assurance, and service activities;

(4) document contracts with independent contractors for qualified supervising professionals, including the number of hours contracted and responsibilities, available to the department upon request; and

(5) comply with section 256B.0949, subdivisions 2, 3a, 6, 7, 14, 15, 16, and 16a.

(b) Provisional license holders must comply with this section within 90 calendar days from the effective date of the provisional license.

Subd. 5. **Reporting of maltreatment.** A provisional license holder must comply with the requirements of reporting of maltreatment of vulnerable adults and minors under section 626.557 and chapter 260E.

Subd. 6. **Background studies.** A provisional license holder must initiate a background study through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 15, and 245C.10, subdivision 17.

Subd. 7. **Sanctions.** If the provisional license holder is not in substantial compliance with the requirements of this section after 90 days following the effective date of the provisional license, the commissioner may either: (1) not renew or terminate the provisional license; or (2) extend the provisional license for a period not to exceed 90 calendar days and apply conditions necessary to bring the facility into substantial compliance. If the provisional license holder is not in substantial compliance within the time allowed by the extension or does not satisfy the license conditions, the commissioner may terminate the license.

Subd. 8. **Reconsideration.** (a) If a provisional license holder disagrees with a sanction under subdivision 7, the provisional license holder may request reconsideration by the

commissioner. The reconsideration request process must be conducted internally by the commissioner and is not an administrative appeal under chapter 14 or section 256.045.

(b) The provisional licensee requesting the reconsideration must make the request in writing and list and describe the reasons why the provisional licensee disagrees with the sanction under subdivision 7.

(c) The reconsideration request and supporting documentation must be received by the commissioner within 15 calendar days after the date the provisional licensee receives notice of the sanction under subdivision 7.

Subd. 9. **Continued operation.** A provisional license holder may continue to operate after receiving notice of nonrenewal or termination:

(1) during the 15 calendar day reconsideration window;

(2) during the pendency of a reconsideration; or

(3) while in active negotiation with the commissioner for an extension of the provisional license with conditions, and the commissioner confirms the negotiation is active.

Subd. 10. **Transition to nonprovisional EIDBI license; future licensure standards.** (a) The commissioner must develop a process and transition plan for comprehensive EIDBI agency licensure by January 1, 2026.

(b) By December 1, 2026, the commissioner shall establish standards for nonprovisional EIDBI agency licensure and submit proposed legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over human services licensing.

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

Sec. 3. Minnesota Statutes 2024, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside;

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program and from working in a children's residential facility or foster residence setting; and

(9) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 2, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense during the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with or access to persons receiving services from the center and from working in a licensed child care center or certified license-exempt child care center.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1, or to a background study for an individual providing early intensive developmental and behavioral intervention services under section 245A.142 or 256B.0949.

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons

receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

EFFECTIVE DATE. This section is effective .....

Sec. 4. Minnesota Statutes 2024, 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). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 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)~~ (c) 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)~~ (d) 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 the day following final enactment.

Sec. 5. Minnesota Statutes 2024, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis.

In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact either in person or by interactive video that meets the requirements in section 256B.0625, subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Except as provided under paragraph (m), payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2. The rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of

responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of management and budget. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

(m) The commissioner may make payments for Tribes according to section 256B.0625, subdivision 34, or other relevant federally approved rate setting methodologies for vulnerable adult and developmental disability targeted case management provided by Indian health services and facilities operated by a Tribe or Tribal organization.

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

Sec. 6. Minnesota Statutes 2024, section 256B.0949, subdivision 15, is amended to read:

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

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

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

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

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

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

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

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

(iii) a board-certified behavior analyst as defined by the Behavior Analyst Certification Board or a qualified behavior analyst as defined by the Qualified Applied Behavior Analysis Credentialing Board; or

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

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

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

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

(ii) has certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board or a qualified autism service practitioner from the Qualified Applied Behavior Analysis Credentialing Board;

(iii) is a registered behavior technician as defined by the Behavior Analyst Certification Board or an applied behavior analysis technician as defined by the Qualified Applied Behavior Analysis Credentialing Board; or

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

(2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2024, section 256B.0949, subdivision 16, is amended to read:

Subd. 16. **Agency duties.** (a) An agency delivering an EIDBI service under this section must:

(1) enroll as a medical assistance Minnesota health care program provider according to Minnesota Rules, part 9505.0195, and section 256B.04, subdivision 21, and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws for EIDBI service;

(3) verify and maintain records of a service provided to the person or the person's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

(4) demonstrate that while enrolled or seeking enrollment as a Minnesota health care program provider the agency did not have a lead agency contract or provider agreement discontinued because of a conviction of fraud; or did not have an owner, board member, or manager fail a state or federal criminal background check or appear on the list of excluded individuals or entities maintained by the federal Department of Human Services Office of Inspector General;

(5) have established business practices including written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality EIDBI services;

(6) have an office located in Minnesota or a border state;

(7) conduct a criminal background check on an individual who has direct contact with the person or the person's legal representative;

(8) report maltreatment according to section 626.557 and chapter 260E;

(9) comply with any data requests consistent with the Minnesota Government Data Practices Act, sections 256B.064 and 256B.27;

(10) provide training for all agency staff on the requirements and responsibilities listed in the Maltreatment of Minors Act, chapter 260E, and the Vulnerable Adult Protection Act, section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's policy for all staff on how to report suspected abuse and neglect;

(11) have a written policy to resolve issues collaboratively with the person and the person's legal representative when possible. The policy must include a timeline for when the person and the person's legal representative will be notified about issues that arise in the provision of services;

(12) provide the person's legal representative with prompt notification if the person is injured while being served by the agency. An incident report must be completed by the agency staff member in charge of the person. A copy of all incident and injury reports must remain on file at the agency for at least five years from the report of the incident; ~~and~~

(13) before starting a service, provide the person or the person's legal representative a description of the treatment modality that the person shall receive, including the staffing certification levels and training of the staff who shall provide a treatment~~.~~;

(14) provide clinical supervision by a qualified supervising professional for a minimum of one hour of supervision for every ten hours of direct treatment per person that meets clinical licensure requirements for quality supervision and effective intervention; and

(15) provide clinical, in-person supervision sessions by a qualified supervising professional at least once per month for intervention, observation, and direction.

(b) When delivering the ITP, and annually thereafter, an agency must provide the person or the person's legal representative with:

(1) a written copy and a verbal explanation of the person's or person's legal representative's rights and the agency's responsibilities;

(2) documentation in the person's file the date that the person or the person's legal representative received a copy and explanation of the person's or person's legal representative's rights and the agency's responsibilities; and

(3) reasonable accommodations to provide the information in another format or language as needed to facilitate understanding of the person's or person's legal representative's rights and the agency's responsibilities.

Sec. 8. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision to read:

Subd. 18. **Provisional licensure.** Beginning on January 1, 2026, the commissioner shall begin issuing provisional licenses to enrolled EIDBI agencies while permanent licensing standards are developed. EIDBI agencies enrolled by December 31, 2025, have 60 calendar days to submit an application for provisional licensure on the forms and in the manner prescribed by the commissioner. The commissioner must act on an application within 90 working days after receiving a complete application.

Sec. 9. Minnesota Statutes 2024, section 256B.19, subdivision 1, is amended to read:

Subdivision 1. **Division of cost.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers;

(2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance;

(3) beginning July 1, 2004, 90 percent state funds and ten percent county funds for the costs of placements that have exceeded 90 days in intermediate care facilities for persons with developmental disabilities that have seven or more beds. This provision includes pass-through payments made under section 256B.5015; ~~and~~

(4) beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county

shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G.~~.~~; and

(5) beginning July 1, 2026, or upon federal approval, whichever is later, 95 percent state funds and five percent county funds for the costs of services for all people receiving community residential services, family residential services, customized living services, or integrated community supports under section 256B.4914.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

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

Sec. 10. Minnesota Statutes 2024, section 256B.49, is amended by adding a subdivision to read:

Subd. 30. **Customized living age limitation.** Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must not authorize customized living services as defined under the brain injury and community access for disability inclusion waiver plans for persons under age 55 unless the person was authorized for customized living services at any time prior to January 1, 2026.

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

Sec. 11. Minnesota Statutes 2024, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) life sharing;

(16) effective until the effective date of clauses (17) and (18), night supervision;

(17) effective January 1, 2026, or upon federal approval, whichever is later, awake night supervision;

(18) effective January 1, 2026, or upon federal approval, whichever is later, asleep night supervision;

~~(17)~~ (19) positive support services;

~~(18)~~ (20) prevocational services;

~~(19)~~ (21) residential support services;

~~(20)~~ (22) respite services;

~~(21)~~ (23) transportation services; and

~~(22)~~ (24) other services as approved by the federal government in the state home and community-based services waiver plan.

(b) Effective January 1, 2024, or upon federal approval, whichever is later, respite services under paragraph (a), clause ~~(20)~~ (22), are not an applicable service under this section.

EFFECTIVE DATE. This section is effective the day following final enactment, except that the amendments to paragraph (b) are effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2024, section 256B.4914, subdivision 5, is amended to read:

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

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

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

(2) on January 1, 2024, based on wage data by SOC from the Bureau of Labor Statistics published in March 2022; and

(3) on January 1, 2026, and every two years thereafter, based on wage data by SOC from the Bureau of Labor Statistics published in the spring approximately 21 months prior to the scheduled update.

(c) Effective January 1, 2026, or upon federal approval, whichever is later, if the result of any base wage index update exceeds two percent, the commissioner must implement a change to the base wage index update of two percent. If the result of any base wage index is less than two percent, the commissioner must implement the full value of the change.

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

Sec. 13. Minnesota Statutes 2024, section 256B.4914, subdivision 5a, is amended to read:

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

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

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

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

(4) for residential asleep-overnight staff, the minimum wage in Minnesota for large employers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(17) effective until the effective date of clauses (18) and (19), for night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093)~~.~~;

(18) effective January 1, 2026, or upon federal approval, whichever is later, for awake night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aid (SOC code 21-1093); and

(19) effective January 1, 2026, or upon federal approval, whichever is later, for asleep night supervision staff, the minimum wage in Minnesota for large employers.

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

Sec. 14. Minnesota Statutes 2024, section 256B.4914, subdivision 5b, is amended to read:

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

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

(2) on January 1, 2024, by the percentage change in the CPI-U from the date of the previous update to the data available as of December 31, 2022; and

(3) on January 1, 2026, and every two years thereafter, by the percentage change in the CPI-U from the date of the previous update to the data available 24 months and one day prior to the scheduled update.

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

Sec. 15. Minnesota Statutes 2024, section 256B.4914, subdivision 6a, is amended to read:

Subd. 6a. **Community residential services; component values and calculation of payment rates.** (a) Component values for community residential services are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

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

(b) Payments for community residential services must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs provided on site or through monitoring technology;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), excluding any shared direct staffing and individual direct staffing hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared direct staffing and individual hours provided through monitoring technology, by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) for transportation, if provided, add $1,742.62 divided by 365, or $3,111.81 divided by 365 if customized for adapted transport, based on the resident with the highest assessed need. The commissioner shall update the amounts in this clause as specified in subdivision 5b;

(11) subtotal clauses (8) to (10) and the direct staffing cost of any shared direct staffing and individual direct staffing hours provided through monitoring technology that was excluded in clause (8);

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

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

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

(c) Effective January 1, 2026, or upon federal approval, whichever is later, community services under this section must be billed at a maximum of 351 days per year.

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

Sec. 16. Minnesota Statutes 2024, section 256B.4914, subdivision 7a, is amended to read:

Subd. 7a. **Adult day services; component values and calculation of payment rates.** (a) Component values for adult day services are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: ~~9.4~~ 3.9 percent.

(b) A unit of service for adult day services is either a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct service.

(c) Payments for adult day services must be calculated as follows:

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

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

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

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

(5) multiply the number of day program direct staffing hours and nursing hours by the appropriate staff wage;

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

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

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

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

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

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs, updated as specified in subdivision 5b;

(12) for adult day bath services, add $7.01 per 15 minute unit;

(13) this is the subtotal rate;

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

(15) divide the result of clause (13) by one minus the result of clause (14). This is the total payment amount; and

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

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 17. Minnesota Statutes 2024, section 256B.4914, subdivision 7b, is amended to read:

Subd. 7b. **Day support services; component values and calculation of payment rates.** (a) Component values for day support services are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 10.37 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: ~~9.4~~ 3.9 percent.

(b) A unit of service for day support services is 15 minutes.

(c) Payments for day support services must be calculated as follows:

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

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

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

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

(5) multiply the number of day program direct staffing hours and nursing hours by the appropriate staff wage;

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

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

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

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

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

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs, updated as specified in subdivision 5b;

(12) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 18. Minnesota Statutes 2024, section 256B.4914, subdivision 7c, is amended to read:

Subd. 7c. **Prevocational services; component values and calculation of payment rates.** (a) Component values for prevocational services are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 10.37 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: ~~9.4~~ 3.9 percent.

(b) A unit of service for prevocational services is either a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct service.

(c) Payments for prevocational services must be calculated as follows:

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

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

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

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

(5) multiply the number of day program direct staffing hours and nursing hours by the appropriate staff wage;

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

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

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

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

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

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs, updated as specified in subdivision 5b;

(12) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 19. Minnesota Statutes 2024, section 256B.4914, subdivision 8, is amended to read:

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

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

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 15.5 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

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

(iv) for night supervision, divide by the number of service recipients, not to exceed two; and

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

(e) Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must bill individualized home supports with training and individualized home supports with family training at a maximum of eight hours per day.

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

Sec. 20. Minnesota Statutes 2024, section 256B.4914, subdivision 9, is amended to read:

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

(b) Effective January 1, 2026, or upon federal approval, whichever is later, for the purposes of this section, unit-based services without programming include individualized home supports without training, awake night supervision, and asleep night supervision provided to an individual outside of any service plan for a day program or residential support service.

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

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

Sec. 21. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 14a. **Limitations on rate exceptions for residential services.** (a) Effective July 1, 2026, the commissioner must implement limitations on the size and number of rate exceptions for community residential services, customized living services, family residential services, and integrated community supports.

(b) The commissioner must restrict rate exceptions to the absence and utilization factor ratio to people temporarily receiving hospital or crisis respite services. The commissioner must not grant an exception for more than 351 leave days per calendar year.

(c) For rate exceptions related to behavioral needs, the commissioner must include:

(1) a documented behavioral diagnosis; or

(2) determined assessed needs for behavioral supports as identified in the person's most recent assessment.

(d) Community residential services rate exceptions must not include positive supports costs.

(e) The commissioner must not approve rate exception requests related to increased community time or transportation.

(f) For the commissioner to approve a rate exception annual renewal, the person's most recent assessment must indicate continued extraordinary needs in the areas cited in the exception request. If a person's assessment continues to identify these extraordinary needs,

lead agencies requesting an annual renewal of rate exceptions must submit provider-created documentation supporting the continuation of the exception, including but not limited to:

(1) payroll records for direct care wages cited in the request;

(2) payment records or receipts for other costs cited in the request; and

(3) documentation of expenses paid that were identified as necessary for the initial rate exception.

(g) The commissioner must not increase rate exception annual renewals that request an exception to direct care or supervision wages more than the most recently implemented base wage index determined under subdivision 5.

(h) The commissioner must publish online an annual report detailing the impact of the limitations under this subdivision on home and community-based services spending, including but not limited to:

(1) the number and percentage of rate exceptions granted and denied;

(2) total spending on community residential setting services and rate exceptions;

(3) trends in the percentage of spending attributable to rate exceptions; and

(4) an evaluation of the effectiveness of the limitations in controlling spending growth.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 22. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 20. **Sanctions and monetary recovery.** Payments under this section are subject to the sanctions and monetary recovery requirements under section 256B.064.

Sec. 23. Minnesota Statutes 2024, 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). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 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)~~ (c) 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)~~ (d) 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 the day following federal approval.

Sec. 24. Minnesota Statutes 2024, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies the person for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies the person for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies the person for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies the person for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies the person for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies the person for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies the person for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies the person for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies the person for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and home care nursing services is limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a person's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living;

(2) 30 additional minutes per day for each complex health-related need; and

(3) 30 additional minutes per day for each behavior under this clause that requires assistance at least four times per week:

(i) level I behavior that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses. This paragraph expires upon the effective date of paragraph (h).

(h) Effective January 1, 2026, or upon federal approval, whichever is later, the service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating and the payment methodologies under section 256B.851; and

(2) an adjustment needed for administrative expenses.

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

Sec. 25. Minnesota Statutes 2024, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that the support worker:

(i) is not disqualified under section 245C.14; or

(ii) is disqualified, but has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. CFSS support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed.

The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS qualify for an enhanced rate if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements. This paragraph expires upon the effective date of paragraph (f).

(f) Effective January 1, 2026, or upon federal approval, whichever is later, CFSS qualify for an enhanced rate or budget if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective the day following federal approval.

Sec. 26. Minnesota Statutes 2024, section 256B.851, subdivision 5, is amended to read:

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

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

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

(3) employee benefits factor, 12.04 percent;

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

(5) program plan support factor, 7.00 percent;

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

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

(8) absence and utilization factor, 3.90 percent.

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

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

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 88.19 percent; and

(3) qualified professional services and CFSS worker training and development: 88.19 percent. This paragraph expires upon the effective date of paragraph (c).

(c) Effective January 1, 2026, or upon federal approval, whichever is later, for purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 92.20 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 92.20 percent; and

(3) qualified professional services and CFSS worker training and development: 92.20 percent.

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

(1) personal care assistance services and CFSS: 92.08 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 92.08 percent; and

(3) qualified professional services and CFSS worker training and development: 92.08 percent. This paragraph expires upon the effective date of paragraph (c).

~~(d)~~ (e) The commissioner shall use the following worker retention components:

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

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 2.17 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.36 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 7.35 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 10.81 percent. This paragraph expires upon the effective date of paragraph (f).

(f) Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner shall use the following worker retention components:

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

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.05 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 6.24 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 9.23 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 12.69 percent.

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

(h) Effective January 1, 2027, or upon federal approval, whichever is later, for purposes of implementation, the commissioner shall use the following implementation components if a worker has completed either the orientation for individual providers offered through the Home Care Orientation Trust or an orientation defined and offered by the commissioner:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.88 percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 5.92 percent;

(3) for workers who have provided between 2,001, and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 8.11 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 11.10 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 14.56 percent.

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

Sec. 27. Minnesota Statutes 2024, section 256B.851, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

(b) In processing personal care assistance provider agency and CFSS provider agency claims, the commissioner shall incorporate the worker retention component specified in subdivision 5, by multiplying one plus the total adjusted payment rate by the appropriate worker retention component under subdivision 5, paragraph (d).

(c) The commissioner must publish the total final payment rates.

(d) The commissioner shall increase the authorization for the CFSS budget model of those CFSS participant-employers employing individual providers who have provided more than 1,000 hours of services as well as individual providers who have completed the orientation offered by the Home Care Orientation Trust or an orientation defined and offered by the commissioner. The commissioner shall determine the amount and method of the authorization increase.

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

Sec. 28. Minnesota Statutes 2024, section 260E.14, subdivision 1, is amended to read:

Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency responsible for investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D.

(c) The Department of Health is the agency responsible for screening and investigating allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of

age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under a provisional license under section 245A.142.

~~(e)~~ (f) A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

~~(f)~~ (g) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in facilities or programs not listed in paragraph (a) that are licensed or certified under chapters 142B and 142C.

EFFECTIVE DATE. This section is effective .....

Sec. 29. Minnesota Statutes 2024, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, family adult day services, mental health programs, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services, including EIDBI agencies operating under a provisional license under section 245A.142.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including, but not limited to, reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

EFFECTIVE DATE. This section is effective .....

Sec. 30. **TRANSITION TO NONPROVISIONAL EIDBI LICENSE; FUTURE LICENSURE STANDARDS.**

(a) The commissioner must develop a process and transition plan for comprehensive EIDBI agency licensure by January 1, 2026.

(b) By December 1, 2026, in consultation with stakeholders the commissioner shall draft standards for nonprovisional EIDBI agency licensure and submit proposed legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over human services licensing.

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

Sec. 31. **BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must increase the consumer-directed community support budgets identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S; and the alternative care program under Minnesota Statutes, section 256B.0913, by 0.13 percent.

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

Sec. 32. **ENHANCED BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must increase the consumer-directed community supports budget exception percentage identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S; and the alternative care program under Minnesota Statutes, section 256B.0913, from 7.5 to 12.5.

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

Sec. 33. **STIPEND PAYMENTS TO SEIU HEALTHCARE MINNESOTA & IOWA BARGAINING UNIT MEMBERS.**

(a) The commissioner of human services shall issue stipend payments to collective bargaining unit members as required by the labor agreement between the state of Minnesota

and the Service Employees International Union (SEIU) Healthcare Minnesota & Iowa and as specified under article 7, section 16, subdivisions 3 and 5.

(b) The definitions in Minnesota Statutes, section 290.01, apply to this section.

(c) For the purposes of this section, "subtraction" has the meaning given in Minnesota Statutes, section 290.0132, subdivision 1, and the rules in that subdivision apply to this section.

(d) The amount of stipend payments received by SEIU Healthcare Minnesota & Iowa collective bargaining unit members under this section is a subtraction.

(e) The amount of stipend payments received by SEIU Healthcare Minnesota & Iowa collective bargaining unit members under this section is excluded from income as defined in Minnesota Statutes, section 290A.03, subdivision 3.

(f) Notwithstanding any law to the contrary, stipend payments under this section must not be considered income, assets, or personal property for purposes of determining or recertifying eligibility for:

(1) child care assistance programs under Minnesota Statutes, chapter 142E;

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

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

(4) the Minnesota family investment program under Minnesota Statutes, chapter 142G; and

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

(g) The commissioner of human services must not consider stipend payments under this section as income or assets under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (a); 3; or 3c, or for persons with eligibility determined under Minnesota Statutes, section 256B.057, subdivision 3, 3a, or 3b.

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

Sec. 34. **RESIDENTIAL OVERNIGHT STAFFING REFORM STUDY.**

(a) The commissioner shall conduct a study of overnight supervision requirements in community residential services as defined in Minnesota Statutes, chapter 245D, to assess and determine the thresholds necessary for an individual to qualify for awake overnight supervision. The study may evaluate:

(1) individual safety needs and risk factors during overnight hours;

(2) the level of support required to address health, behavioral, and environmental risks;

(3) the cost-effectiveness and resource allocation of awake versus asleep overnight supervision models;

(4) staffing and workforce implications for providers of community residential services; and

(5) feedback and recommendations from stakeholders, including service recipients, families of service recipients, and providers.

(b) By June 30, 2027, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services finance and policy. The report must outline the findings from the study, including any identified thresholds for awake overnight supervision eligibility and recommendations for implementing evidence-based guidelines to enhance service delivery and individual safety.

ARTICLE 3
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2024, section 13.46, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** As used in this section:

(a) "Individual" means an individual according to section 13.02, subdivision 8, but does not include a vendor of services.

(b) "Program" includes all programs for which authority is vested in a component of the welfare system according to statute or federal law, including but not limited to Native American Tribe programs that provide a service component of the welfare system, the Minnesota family investment program, medical assistance, general assistance, general assistance medical care formerly codified in chapter 256D, the child care assistance program, and child support collections.

(c) "Welfare system" includes the Department of Human Services; Direct Care and Treatment; the Department of Children, Youth, and Families; local social services agencies; county welfare agencies; county public health agencies; county veteran services agencies; county housing agencies; private licensing agencies; the public authority responsible for child support enforcement; human services boards; community mental health center boards, state hospitals, state nursing homes, the ombudsman for mental health and developmental

disabilities; Native American Tribes to the extent a Tribe provides a service component of the welfare system; the Minnesota Competency Attainment Board and forensic navigators under chapter 611; and persons, agencies, institutions, organizations, and other entities under contract to any of the above agencies to the extent specified in the contract.

(d) "Mental health data" means data on individual clients and patients of community mental health centers, established under section 245.62, mental health divisions of counties and other providers under contract to deliver mental health services, Direct Care and Treatment mental health services, or the ombudsman for mental health and developmental disabilities.

(e) "Fugitive felon" means a person who has been convicted of a felony and who has escaped from confinement or violated the terms of probation or parole for that offense.

(f) "Private licensing agency" means an agency licensed by the commissioner of children, youth, and families under chapter 142B to perform the duties under section 142B.30.

Sec. 2. Minnesota Statutes 2024, section 246B.10, is amended to read:

246B.10 LIABILITY OF COUNTY; REIMBURSEMENT.

(a) The civilly committed sex offender's county shall pay to the state a portion of the cost of care provided in the Minnesota Sex Offender Program to a civilly committed sex offender who has legally settled in that county.

(b) A county's payment must be made from the county's own sources of revenue and payments must~~:~~

~~(1)~~ equal ~~ten~~ 40 percent of the cost of care, as determined by the executive board, for each day or portion of a day that the civilly committed sex offender spends at the facility ~~for individuals admitted to the Minnesota Sex Offender Program before August 1, 2011;~~ or

~~(2) equal 25 percent of the cost of care, as determined by the executive board, for each day or portion of a day that the civilly committed sex offender:~~

~~(i) spends at the facility for individuals admitted to the Minnesota Sex Offender Program on or after August 1, 2011; or~~

~~(ii)~~ receives services within a program operated by the Minnesota Sex Offender Program while on provisional discharge.

(c) The county is responsible for paying the state the remaining amount if payments received by the state under this chapter exceed~~:~~

~~(1) 90 percent of the cost of care for individuals admitted to the Minnesota Sex Offender Program before August 1, 2011; or~~

~~(2) 75~~ 60 percent of the cost of care for individuals~~:~~.

~~(i) admitted to the Minnesota Sex Offender Program on or after August 1, 2011; or~~

~~(ii) receiving services within a program operated by the Minnesota Sex Offender Program while on provisional discharge.~~

(d) The county is not entitled to reimbursement from the civilly committed sex offender, the civilly committed sex offender's estate, or from the civilly committed sex offender's relatives, except as provided in section 246B.07.

Sec. 3. Minnesota Statutes 2024, section 256G.01, subdivision 3, is amended to read:

Subd. 3. **Program coverage.** This chapter applies to all social service programs administered by the commissioner of human services or the Direct Care and Treatment executive board in which residence is the determining factor in establishing financial responsibility. These include, but are not limited to: commitment proceedings, including voluntary admissions; emergency holds; competency proceedings under chapter 611; poor relief funded wholly through local agencies; social services, including title XX, IV-E and section 256K.10; social services programs funded wholly through the resources of county agencies; social services provided under the Minnesota Indian Family Preservation Act, sections 260.751 to 260.781; costs for delinquency confinement under section 393.07, subdivision 2; service responsibility for these programs; and housing support under chapter 256I.

Sec. 4. Minnesota Statutes 2024, section 256G.08, subdivision 1, is amended to read:

Subdivision 1. **Commitment and competency proceedings.** In cases of voluntary admission, ~~or~~ commitment to state or other institutions, or criminal orders for inpatient examination or participation in a competency attainment program under chapter 611, the committing county or the county from which the first criminal order for inpatient examination or order for participation in a competency attainment program under chapter 611 is issued shall initially pay for all costs. This includes the expenses of the taking into custody, confinement, emergency holds under sections 253B.051, subdivisions 1 and 2, and 253B.07, examination, commitment, conveyance to the place of detention, rehearing, and hearings under ~~section~~ sections 253B.092 and 611.47, including hearings held under ~~that section~~

~~which~~ those sections that are venued outside the county of commitment or the county of the chapter 611 competency proceedings order.

Sec. 5. Minnesota Statutes 2024, section 256G.08, subdivision 2, is amended to read:

Subd. 2. **Responsibility for nonresidents.** If a person committed, ~~or~~ voluntarily admitted to a state institution, or ordered for inpatient examination or participation in a competency attainment program under chapter 611 has no residence in this state, financial responsibility belongs to the county of commitment or the county from which the first criminal order for inpatient examination or order for participation in a competency attainment program under chapter 611 was issued.

Sec. 6. Minnesota Statutes 2024, section 256G.09, subdivision 1, is amended to read:

Subdivision 1. **General procedures.** If upon investigation the local agency decides that the application, ~~or~~ commitment, or first criminal order under chapter 611 was not filed in the county of financial responsibility as defined by this chapter, but that the applicant is otherwise eligible for assistance, it shall send a copy of the application, ~~or~~ commitment claim, or chapter 611 claim together with the record of any investigation it has made, to the county it believes is financially responsible. The copy and record must be sent within 60 days of the date the application was approved or the claim was paid. The first local agency shall provide assistance to the applicant until financial responsibility is transferred under this section.

The county receiving the transmittal has 30 days to accept or reject financial responsibility. A failure to respond within 30 days establishes financial responsibility by the receiving county.

Sec. 7. Minnesota Statutes 2024, section 256G.09, subdivision 2, is amended to read:

Subd. 2. **Financial disputes.** (a) If the county receiving the transmittal does not believe it is financially responsible, it should provide to the commissioner of human services and the initially responsible county a statement of all facts and documents necessary for the commissioner to make the requested determination of financial responsibility. The submission must clearly state the program area in dispute and must state the specific basis upon which the submitting county is denying financial responsibility.

(b) The initially responsible county then has 15 calendar days to submit its position and any supporting evidence to the commissioner. The absence of a submission by the initially responsible county does not limit the right of the commissioner of human services or Direct

Care and Treatment executive board to issue a binding opinion based on the evidence actually submitted.

(c) A case must not be submitted until the local agency taking the application, ~~or~~ making the commitment, or residing in the county from which the first criminal order under chapter 611 was issued has made an initial determination about eligibility and financial responsibility, and services have been initiated. This paragraph does not prohibit the submission of closed cases that otherwise meet the applicable statute of limitations.

Sec. 8. Minnesota Statutes 2024, section 611.43, is amended by adding a subdivision to read:

Subd. 5. **Costs related to confined treatment.** (a) When a defendant is ordered to participate in an examination in a treatment facility, a locked treatment facility, or a state-operated treatment facility under subdivision 1, paragraph (b), the facility shall bill the responsible health plan first. The county in which the criminal charges are filed is responsible to pay any charges not covered by the health plan, including co-pays and deductibles. If the defendant has health plan coverage and is confined in a hospital, but the hospitalization does not meet the criteria in section 62M.07, subdivision 2, clause (1); 62Q.53; 62Q.535, subdivision 1; or 253B.045, subdivision 6, the county in which criminal charges are filed is responsible for payment.

(b) The Direct Care and Treatment executive board shall determine the cost of confinement in a state-operated treatment facility based on the executive board's determination of cost of care pursuant to section 246.50, subdivision 5.

Sec. 9. Minnesota Statutes 2024, section 611.46, subdivision 1, is amended to read:

Subdivision 1. **Order to competency attainment program.** (a) If the court finds the defendant incompetent and the charges have not been dismissed, the court shall order the defendant to participate in a program to assist the defendant in attaining competency. The court may order participation in a competency attainment program provided outside of a jail, a jail-based competency attainment program, or an alternative program. The court must determine the least-restrictive program appropriate to meet the defendant's needs and public safety. In making this determination, the court must consult with the forensic navigator and consider any recommendations of the court examiner. The court shall not order a defendant to participate in a jail-based program or a state-operated treatment program if the highest criminal charge is a targeted misdemeanor.

(b) If the court orders the defendant to a locked treatment facility or jail-based program, the court must calculate the defendant's custody credit and cannot order the defendant to a locked treatment facility or jail-based program for a period that would cause the defendant's custody credit to exceed the maximum sentence for the underlying charge.

(c) The court may only order the defendant to participate in competency attainment at an inpatient or residential treatment program under this section if the head of the treatment program determines that admission to the program is clinically appropriate and consents to the defendant's admission. The court may only order the defendant to participate in competency attainment at a state-operated treatment facility under this section if the Direct Care and Treatment executive board or a designee determines that admission of the defendant is clinically appropriate and consents to the defendant's admission. The court may require a competency program that qualifies as a locked facility or a state-operated treatment program to notify the court in writing of the basis for refusing consent for admission of the defendant in order to ensure transparency and maintain an accurate record. The court may not require personal appearance of any representative of a competency program. The court shall send a written request for notification to the locked facility or state-operated treatment program and the locked facility or state-operated treatment program shall provide a written response to the court within ten days of receipt of the court's request.

(d) If the defendant is confined in jail and has not received competency attainment services within 30 days of the finding of incompetency, the court shall review the case with input from the prosecutor and defense counsel and may:

(1) order the defendant to participate in an appropriate competency attainment program that takes place outside of a jail;

(2) order a conditional release of the defendant with conditions that include but are not limited to a requirement that the defendant participate in a competency attainment program when one becomes available and accessible;

(3) make a determination as to whether the defendant is likely to attain competency in the reasonably foreseeable future and proceed under section 611.49; or

(4) upon a motion, dismiss the charges in the interest of justice.

(e) The court may order any hospital, treatment facility, or correctional facility that has provided care or supervision to a defendant in the previous two years to provide copies of the defendant's medical records to the competency attainment program or alternative program in which the defendant was ordered to participate. This information shall be provided in a consistent and timely manner and pursuant to all applicable laws.

(f) If at any time the defendant refuses to participate in a competency attainment program or an alternative program, the head of the program shall notify the court and any entity responsible for supervision of the defendant.

(g) At any time, the head of the program may discharge the defendant from the program or facility. The head of the program must notify the court, prosecutor, defense counsel, and any entity responsible for the supervision of the defendant prior to any planned discharge. Absent emergency circumstances, this notification shall be made five days prior to the discharge if the defendant is not being discharged to jail or a correctional facility. Upon the receipt of notification of discharge or upon the request of either party in response to notification of discharge, the court may order that a defendant who is subject to bail or unmet conditions of release be returned to jail upon being discharged from the program or facility. If the court orders a defendant returned to jail, the court shall notify the parties and head of the program at least one day before the defendant's planned discharge, except in the event of an emergency discharge where one day notice is not possible. The court must hold a review hearing within seven days of the defendant's return to jail. The forensic navigator must be given notice of the hearing and be allowed to participate.

(h) If the defendant is discharged from the program or facility under emergency circumstances, notification of emergency discharge shall include a description of the emergency circumstances and may include a request for emergency transportation. The court shall make a determination on a request for emergency transportation within 24 hours. Nothing in this section prohibits a law enforcement agency from transporting a defendant pursuant to any other authority.

(i) If the defendant is ordered to participate in an inpatient or residential competency attainment or alternative program, the program or facility must notify the court, prosecutor, defense counsel, and any entity responsible for the supervision of the defendant if the defendant is placed on a leave or elopement status from the program and if the defendant returns to the program from a leave or elopement status.

(j) Defense counsel and prosecutors must have access to information relevant to a defendant's participation and treatment in a competency attainment program or alternative program, including but not limited to discharge planning.

Sec. 10. Minnesota Statutes 2024, section 611.55, is amended by adding a subdivision to read:

Subd. 5. **Data access.** Forensic navigators must have access to all data collected, created, or maintained by a competency attainment program or an alternative program regarding a

defendant in order for navigators to carry out their duties under this section. A competency attainment program or alternative program may request a copy of the court order appointing the forensic navigator before disclosing any private information about a defendant.

ARTICLE 4
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2024, section 245.4661, subdivision 2, is amended to read:

Subd. 2. **Program design and implementation.** Adult mental health initiatives shall be responsible for designing, planning, improving, and maintaining a mental health service delivery system for adults with serious and persistent mental illness that would:

(1) provide an expanded array of services from which clients can choose services appropriate to their needs;

(2) be based on purchasing strategies that improve access and coordinate services without cost shifting;

(3) prioritize evidence-based services and implement services that are promising practices or theory-based practices so that the service can be evaluated according to subdivision 5a;

(4) incorporate existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors; and

(5) utilize ~~existing categorical funding streams and reimbursement sources in combined and creative ways, except~~ adult mental health initiative funding only after all other eligible funding sources have been applied. Appropriations and all funds that are attributable to the operation of state-operated services under the control of the Direct Care and Treatment executive board are excluded unless appropriated specifically by the legislature for a purpose consistent with this section.

Sec. 2. Minnesota Statutes 2024, section 245.4661, subdivision 6, is amended to read:

Subd. 6. **Duties of commissioner.** (a) For purposes of adult mental health initiatives, the commissioner shall facilitate integration of funds or other resources as needed and requested by each adult mental health initiative. These resources may include:

(1) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(2) other mental health special project funds;

(3) medical assistance, MinnesotaCare, and housing support under chapter 256I if requested by the adult mental health initiative's managing entity and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(4) regional treatment center resources, with consent from the Direct Care and Treatment executive board.

~~(b) The commissioner shall consider the following criteria in awarding grants for adult mental health initiatives:~~

~~(1) the ability of the initiatives to accomplish the objectives described in subdivision 2;~~

~~(2) the size of the target population to be served; and~~

~~(3) geographical distribution.~~

~~(c)~~ (b) The commissioner shall review overall status of the initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

~~(d)~~ (c) The commissioner may waive administrative rule requirements that are incompatible with the implementation of the adult mental health initiative.

~~(e)~~ (d) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules that are incompatible with the implementation of the adult mental health initiative.

~~(f)~~ (e) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the adult mental health initiative.

Sec. 3. Minnesota Statutes 2024, section 245.4661, subdivision 7, is amended to read:

Subd. 7. **Duties of adult mental health initiative board.** The adult mental health initiative board, or other entity which is approved to administer an adult mental health initiative, shall:

(1) administer the initiative in a manner that is consistent with the objectives described in subdivision 2 and the planning process described in subdivision 5;

(2) assure that no one is denied services that they would otherwise be eligible for; and

(3) provide the commissioner of human services with timely and pertinent information through ~~the following methods:~~

~~(i) submission of mental health plans and plan amendments which are based on a format and timetable determined by the commissioner;~~

~~(ii) submission of social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the initiative's managing entity and the commissioner; and~~

~~(iii)~~ submission of data and participation in an evaluation of the adult mental health initiatives, to be designed cooperatively by the commissioner and the initiatives. For services provided to American Indians in Tribal nations or urban Indian communities, oral reports using a system designed in partnership between the commissioner and the reporting community satisfy the requirements of this clause.

Sec. 4. Minnesota Statutes 2024, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency, facility, or program that provides services or treatment for mental illness, developmental disability, substance use disorder, or emotional disturbance that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; a ~~sober home~~ recovery residence as defined in section 254B.01, subdivision 11; peer recovery support services provided by a recovery community organization as defined in section 254B.01, subdivision 8; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, substance use disorder, or emotional disturbance.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 5. Minnesota Statutes 2024, section 245G.01, subdivision 13b, is amended to read:

Subd. 13b. **Guest speaker.** "Guest speaker" means an individual who is not an alcohol and drug counselor qualified according to section 245G.11, subdivision 5; is not qualified according to the commissioner's list of professionals under section 245G.07, subdivision 3, clause (1); and who works under the direct observation of an alcohol and drug counselor to present to clients on topics in which the guest speaker has expertise and that the license holder has determined to be beneficial to a client's recovery. Tribally licensed programs have autonomy to identify the qualifications of their guest speakers.

Sec. 6. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 13d. **Individual counseling.** "Individual counseling" means professionally led psychotherapeutic treatment for substance use disorders that is delivered in a one-to-one setting or in a setting with the client and the client's family and other natural supports.

Sec. 7. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 20f. **Psychoeducation.** "Psychoeducation" means the services described in section 245G.07, subdivision 1a, clause (2).

Sec. 8. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 20g. **Psychosocial treatment services.** "Psychosocial treatment services" means the services described in section 245G.07, subdivision 1a.

Sec. 9. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 20h. **Recovery support services.** "Recovery support services" means the services described in section 245G.07, subdivision 2a, paragraph (b), clause (1).

Sec. 10. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 26a. **Treatment coordination.** "Treatment coordination" means the services described in section 245G.07, subdivision 1b.

Sec. 11. Minnesota Statutes 2024, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph

(c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 1a, and 4; 245G.07, ~~subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7)~~ subdivision 1a, clause (2); and 245G.17.

EFFECTIVE DATE. This section is effective July 1, 2026.

Sec. 12. Minnesota Statutes 2024, section 245G.07, subdivision 1, is amended to read:

Subdivision 1. **Treatment service.** (a) A licensed ~~residential~~ treatment program must offer the treatment services in ~~clauses (1) to (5)~~ subdivisions 1a and 1b and may offer the treatment services in subdivision 2 to each client, unless clinically inappropriate and the justifying clinical rationale is documented. ~~A nonresidential~~ The treatment program must ~~offer all treatment services in clauses (1) to (5) and~~ document in the individual treatment plan the specific services for which a client has an assessed need and the plan to provide the services~~:~~.

~~(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;~~

~~(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis;~~

~~(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;~~

~~(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan; and~~

~~(5) treatment coordination provided one-to-one by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Treatment coordination services include:~~

~~(i) assistance in coordination with significant others to help in the treatment planning process whenever possible;~~

~~(ii) assistance in coordination with and follow up for medical services as identified in the treatment plan;~~

~~(iii) facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;~~

~~(iv) facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;~~

~~(v) assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;~~

~~(vi) life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and~~

~~(vii) documentation of the provision of treatment coordination services in the client's file.~~

(b) A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client.

(c) A supportive service alone does not constitute a treatment service. Supportive services include:

(1) milieu management or supervising or monitoring clients without also providing a treatment service identified in subdivision 1a, 1b, or 2a;

(2) transporting clients; and

(3) waiting with clients for appointments at social service agencies, court hearings, and similar activities.

(d) A treatment service provided in a group setting must be provided in a cohesive manner and setting that allows every client receiving the service to interact and receive the same service at the same time.

Sec. 13. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision to read:

Subd. 1a. **Psychosocial treatment service.** Psychosocial treatment services must be provided according to the hours identified in section 254B.19 for the ASAM level of care provided to the client. A license holder must provide the following psychosocial treatment services as a part of the client's individual treatment:

(1) counseling services that provide a client with professional assistance in managing substance use disorder and co-occurring conditions, either individually or in a group setting. Counseling must:

(i) utilization of evidence-based techniques to help a client modify behavior, overcome obstacles, and achieve and sustain recovery through techniques such as active listening, guidance, discussion, feedback, and clarification;

(ii) help for the client to identify and address needs related to substance use, develop strategies to avoid harmful substance use, and establish a lifestyle free of the harmful effects of substance use disorder; and

(iii) work to improve well-being and mental health, resolve or mitigate symptomatic behaviors, beliefs, compulsions, thoughts, and emotions, and enhance relationships and social skills, while addressing client-centered psychological and emotional needs; and

(2) psychoeducation services to provide a client with information about substance use and co-occurring conditions, either individually or in a group setting. Psychoeducation includes structured presentations, interactive discussions, and practical exercises to help clients understand and manage their conditions effectively. Topics include but are not limited to:

(i) the causes of substance use disorder and co-occurring disorders;

(ii) behavioral techniques that help a client change behaviors, thoughts, and feelings;

(iii) the importance of maintaining mental health, including understanding symptoms of mental illness;

(iv) medications for addiction and psychiatric disorders and the importance of medication adherence;

(v) the importance of maintaining physical health, health-related risk factors associated with substance use disorder, and specific health education on tuberculosis, HIV, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis; and

(vi) harm-reduction strategies.

Sec. 14. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision to read:

Subd. 1b. **Treatment coordination.** (a) Treatment coordination must be provided one-to-one by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Treatment coordination services include:

(1) coordinating directly with others involved in the client's treatment and recovery, including the referral source, family or natural supports, social services agencies, and external care providers;

(2) providing clients with training and facilitating connections to community resources that support recovery;

(3) assisting clients in obtaining necessary resources and services such as financial assistance, housing, food, clothing, medical care, education, harm reduction services, vocational support, and recreational services that promote recovery;

(4) helping clients connect and engage with self-help support groups and expand social support networks with family, friends, and organizations; and

(5) assisting clients in transitioning between levels of care, including providing direct connections to ensure continuity of care.

(b) Treatment coordination does not include coordinating services or communicating with staff members within the licensed program.

(c) Treatment coordination may be provided in a setting with the individual client and others involved in the client's treatment and recovery.

Sec. 15. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision to read:

Subd. 2a. **Ancillary treatment service.** (a) A license holder may provide ancillary services in addition to the hours of psychosocial treatment services identified in section 254B.19 for the ASAM level of care provided to the client.

(b) A license holder may provide the following ancillary treatment services as a part of the client's individual treatment:

(1) recovery support services provided individually or in a group setting, that include:

(i) supporting clients in restoring daily living skills, such as health and health care navigation and self-care to enhance personal well-being;

(ii) providing resources and assistance to help clients restore life skills, including effective parenting, financial management, pro-social behavior, education, employment, and nutrition;

(iii) assisting clients in restoring daily functioning and routines affected by substance use and supporting them in developing skills for successful community integration; and

(iv) helping clients respond to or avoid triggers that threaten their community stability, assisting the client in identifying potential crises and developing a plan to address them, and providing support to restore the client's stability and functioning; and

(2) peer recovery support services provided according to sections 254B.05, subdivision 5, and 254B.052.

Sec. 16. Minnesota Statutes 2024, section 245G.07, subdivision 3, is amended to read:

Subd. 3. ~~**Counselors**~~ **Treatment service providers.** (a) All treatment services~~, except peer recovery support services and treatment coordination,~~ must be provided by an ~~alcohol and drug counselor qualified according to section 245G.11, subdivision 5, unless the~~ individual ~~providing the service is~~ specifically qualified according to the accepted credential required to provide the service. ~~The commissioner shall maintain a current list of professionals qualified to provide treatment services.~~

(b) Psychosocial treatment services must be provided by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5, unless the individual providing the service is specifically qualified according to the accepted credential required to provide the service. The commissioner shall maintain a current list of professionals qualified to provide psychosocial treatment services.

(c) Treatment coordination must be provided by a treatment coordinator qualified according to section 245G.11, subdivision 7.

(d) Recovery support services must be provided by a behavioral health practitioner qualified according to section 245G.11, subdivision 12.

(e) Peer recovery support services must be provided by a recovery peer qualified according to section 245I.04, subdivision 18.

Sec. 17. Minnesota Statutes 2024, section 245G.07, subdivision 4, is amended to read:

Subd. 4. **Location of service provision.** (a) The license holder must provide all treatment services a client receives at one of the license holder's substance use disorder treatment licensed locations or at a location allowed under paragraphs (b) to (f). If the services are provided at the locations in paragraphs (b) to (d), the license holder must document in the client record the location services were provided.

(b) The license holder may provide nonresidential individual treatment services at a client's home or place of residence.

(c) If the license holder provides treatment services by telehealth, the services must be provided according to this paragraph:

(1) the license holder must maintain a licensed physical location in Minnesota where the license holder must offer all treatment services in subdivision ~~1, paragraph (a), clauses (1) to (4),~~ 1a physically in-person to each client;

(2) the license holder must meet all requirements for the provision of telehealth in sections 254B.05, subdivision 5, paragraph (f), and 256B.0625, subdivision 3b. The license holder must document all items in section 256B.0625, subdivision 3b, paragraph (c), for each client receiving services by telehealth, regardless of payment type or whether the client is a medical assistance enrollee;

(3) the license holder may provide treatment services by telehealth to clients individually;

(4) the license holder may provide treatment services by telehealth to a group of clients that are each in a separate physical location;

(5) the license holder must not provide treatment services remotely by telehealth to a group of clients meeting together in person, unless permitted under clause (7);

(6) clients and staff may join an in-person group by telehealth if a staff member qualified to provide the treatment service is physically present with the group of clients meeting together in person; and

(7) the qualified professional providing a residential group treatment service by telehealth must be physically present on-site at the licensed residential location while the service is being provided. If weather conditions or short-term illness prohibit a qualified professional from traveling to the residential program and another qualified professional is not available to provide the service, a qualified professional may provide a residential group treatment service by telehealth from a location away from the licensed residential location. In such circumstances, the license holder must ensure that a qualified professional does not provide a residential group treatment service by telehealth from a location away from the licensed residential location for more than one day at a time, must ensure that a staff person who qualifies as a paraprofessional is physically present with the group of clients, and must document the reason for providing the remote telehealth service in the records of clients receiving the service. The license holder must document the dates that residential group treatment services were provided by telehealth from a location away from the licensed residential location in a central log and must provide the log to the commissioner upon request.

(d) The license holder may provide the ~~additional~~ ancillary treatment services under subdivision ~~2, clauses (2) to (6) and (8),~~ 2a away from the licensed location at a suitable location appropriate to the treatment service.

(e) Upon written approval from the commissioner for each satellite location, the license holder may provide nonresidential treatment services at satellite locations that are in a school, jail, or nursing home. A satellite location may only provide services to students of the school, inmates of the jail, or residents of the nursing home. Schools, jails, and nursing homes are exempt from the licensing requirements in section 245A.04, subdivision 2a, to document compliance with building codes, fire and safety codes, health rules, and zoning ordinances.

(f) The commissioner may approve other suitable locations as satellite locations for nonresidential treatment services. The commissioner may require satellite locations under this paragraph to meet all applicable licensing requirements. The license holder may not have more than two satellite locations per license under this paragraph.

(g) The license holder must provide the commissioner access to all files, documentation, staff persons, and any other information the commissioner requires at the main licensed location for all clients served at any location under paragraphs (b) to (f).

(h) Notwithstanding sections 245A.65, subdivision 2, and 626.557, subdivision 14, a program abuse prevention plan is not required for satellite or other locations under paragraphs (b) to (e). An individual abuse prevention plan is still required for any client that is a vulnerable adult as defined in section 626.5572, subdivision 21.

Sec. 18. Minnesota Statutes 2024, section 245G.11, subdivision 6, is amended to read:

Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights, according to section 148F.165, and staff member responsibilities. A paraprofessional may not make decisions to admit, transfer, or discharge a client but may perform tasks related to intake and orientation. A paraprofessional may be the responsible ~~for the delivery of treatment service~~ staff member according to section 245G.10, subdivision 3. A paraprofessional is not qualified to provide a treatment service according to section 245G.07, subdivisions 1a, 1b, and 2a.

Sec. 19. Minnesota Statutes 2024, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment

coordination if the individual meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on treatment coordination for an individual with substance use disorder;

(4) has ~~either:~~ a high school diploma or equivalent; and

~~(i) a bachelor's degree in one of the behavioral sciences or related fields; or~~

~~(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and~~

(5) has at least ~~2,000~~ 1,000 hours of supervised experience working with individuals with substance use disorder.

(b) A treatment coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor, or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.

Sec. 20. Minnesota Statutes 2024, section 245G.11, is amended by adding a subdivision to read:

Subd. 12. **Behavioral health practitioners.** (a) A behavioral health practitioner must meet the qualifications in section 245I.04, subdivision 4.

(b) A behavioral health practitioner working within a substance use disorder treatment program licensed under this chapter has the following scope of practice:

(1) a behavioral health practitioner may provide clients with recovery support services, as defined in section 245G.07, subdivision 2a, paragraph (b), clause (1); and

(2) a behavioral health practitioner must not provide treatment supervision to other staff persons.

(c) A behavioral health practitioner working within a substance use disorder treatment program licensed under this chapter must receive at least one hour of supervision per month on individual service delivery from an alcohol and drug counselor or a mental health

professional who has substance use treatment and assessments within the scope of their practice.

Sec. 21. Minnesota Statutes 2024, section 245G.22, subdivision 11, is amended to read:

Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system. If the person seeking admission cannot be admitted within 14 days of the date of application, each person seeking admission must be placed on the waiting list, unless the person seeking admission is assessed by the program and found ineligible for admission according to this chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12 (e), and title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each person seeking treatment while awaiting admission. A person seeking admission on a waiting list who receives no services under section 245G.07, subdivision ~~1~~ 1a or 1b, must not be considered a client as defined in section 245G.01, subdivision 9.

Sec. 22. Minnesota Statutes 2024, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision ~~1, paragraph (a)~~ 1a, clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

Sec. 23. Minnesota Statutes 2024, section 254A.19, subdivision 4, is amended to read:

Subd. 4. **Civil commitments.** For the purposes of determining level of care, a comprehensive assessment does not need to be completed for an individual being committed as a chemically dependent person, as defined in section 253B.02, and for the duration of a civil commitment under section 253B.09 or 253B.095 in order for ~~a county~~ the individual to ~~access~~ be eligible for the behavioral health fund under section 254B.04. The ~~county~~ commissioner must determine if the individual meets the financial eligibility requirements for the behavioral health fund under section 254B.04.

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

Sec. 24. Minnesota Statutes 2024, section 254B.01, subdivision 10, is amended to read:

Subd. 10. **~~Skilled~~ Psychosocial treatment services.** "~~Skilled~~ Psychosocial treatment services" includes the treatment services described in section 245G.07, ~~subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled~~ subdivision 1a. Psychosocial treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3, paragraph (b).

Sec. 25. Minnesota Statutes 2024, section 254B.01, subdivision 11, is amended to read:

Subd. 11. **~~Sober home~~ Recovery residence.** A ~~sober home~~ recovery residence is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that:

(1) provides temporary housing to persons with substance use disorders;

(2) stipulates that residents must abstain from using alcohol or other illicit drugs or substances not prescribed by a physician;

(3) charges a fee for living there;

(4) does not provide counseling or treatment services to residents;

(5) promotes sustained recovery from substance use disorders; and

(6) follows the sober living guidelines published by the federal Substance Abuse and Mental Health Services Administration.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 26. Minnesota Statutes 2024, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **~~Local agency~~ Tribal allocation.** The commissioner may make payments to ~~local agencies~~ Tribal Nation servicing agencies from money allocated under this section to support individuals with substance use disorders and determine eligibility for behavioral health fund payments. The payment must not be less than 133 percent of the ~~local agency~~ Tribal Nations payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

Sec. 27. Minnesota Statutes 2024, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. ~~**Local agency duties**~~ **Financial eligibility determinations.** (a) ~~Every local agency~~ The commissioner of human services or Tribal Nation servicing agencies must determine financial eligibility for substance use disorder services and provide substance use disorder services to persons residing within its jurisdiction who meet criteria established by the commissioner. Substance use disorder money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of substance use disorder services who can provide economical and appropriate treatment. ~~Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05.~~ The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

(c) An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

~~(d) Beginning July 1, 2022, local agencies shall not make placement location determinations.~~

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

Sec. 28. Minnesota Statutes 2024, section 254B.03, subdivision 3, is amended to read:

Subd. 3. ~~**Local agencies**~~ **Counties to pay state for county share.** ~~Local agencies~~ Counties shall pay the state for the county share of the services authorized by the ~~local agency~~ commissioner, except when the payment is made according to section 254B.09, subdivision 8.

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

Sec. 29. Minnesota Statutes 2024, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for ~~22.95~~ 50 percent of the cost of substance use disorder services, except for ~~those~~ individuals living in carceral settings. The county shall pay the state 22.95 percent of the cost of substance use disorder services for individuals in carceral settings. Services provided to persons enrolled in medical assistance under chapter 256B and room and board services under section 254B.05, subdivision 5, paragraph (b), are exempted from county contributions. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) ~~22.95~~ 50 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

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

Sec. 30. Minnesota Statutes 2024, section 254B.04, subdivision 1a, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the ~~local agency~~ commissioner to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (9).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 142G;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to ~~9505.0150~~ 9505.140;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to ~~9500.1318~~ 9500.1272; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by ~~a local agency~~ the commissioner under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.05, subdivision 4.

(i) Persons enrolled in MinnesotaCare are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section 256B.0622.

(j) A person is eligible for one 60-consecutive-calendar-day period per year. A person may submit a request for additional eligibility to the commissioner. A person denied additional eligibility under this paragraph may request a state agency hearing under section 256.045.

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

Sec. 31. Minnesota Statutes 2024, section 254B.04, subdivision 5, is amended to read:

Subd. 5. **~~Local agency~~ Commissioner responsibility to provide administrative services.** The ~~local agency~~ commissioner of human services may employ individuals to conduct administrative activities and facilitate access to substance use disorder treatment services.

Sec. 32. Minnesota Statutes 2024, section 254B.04, subdivision 6, is amended to read:

Subd. 6. **~~Local agency~~ Commissioner to determine client financial eligibility.** (a) The ~~local agency~~ commissioner 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 request. The ~~local agency~~ commissioner shall pay for eligible clients according to chapter 256G. Client eligibility must be determined using only forms prescribed by the 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~~ commissioner 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~~ commissioner 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~~ commissioner 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)~~ (e) The ~~local agency~~ commissioner 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)~~ (f) The ~~local agency~~ commissioner must ~~redetermine~~ determine a client's eligibility for the behavioral health fund ~~every 12 months~~ for a 60-consecutive-calendar-day period per calendar year.

~~(h)~~ (g) 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)~~ (e). 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. 33. Minnesota Statutes 2024, section 254B.04, subdivision 6a, is amended to read:

Subd. 6a. **Span of eligibility.** The ~~local agency~~ commissioner 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. 34. Minnesota Statutes 2024, 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 provided according to section 254A.19, subdivision 3, 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).~~ subdivisions 1, 1a, and 1b.

(c) A county is an eligible vendor for a comprehensive assessment 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 254A.19, subdivision 3. A county is an eligible vendor of ~~care~~ treatment 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)~~ 1b. 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, and according to section 254B.052.

(d) A recovery community organization that meets the requirements of clauses (1) to (14) and meets certification or accreditation requirements of the Alliance for Recovery Centered Organizations, the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification or accreditation on the status of the application within 45 days of receipt. If the approved statewide recovery organization denies an application, it must provide a written explanation for the denial to the recovery community organization. Eligible vendors under this paragraph must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be free from conflicting self-interests, and be autonomous in decision-making, program development, peer recovery support services provided, and advocacy efforts for the purpose of supporting the recovery community organization's mission;

(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) have a mission statement and conduct corresponding activities indicating that the organization's primary purpose is to support recovery from substance use disorder;

(4) demonstrate ongoing community engagement with the identified primary region and population served by the organization, including individuals in recovery and their families, friends, and recovery allies;

(5) be accountable to the recovery community through documented priority-setting and participatory decision-making processes that promote the 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, and harm-reduction activities, and provide recovery public education and advocacy;

(7) have written policies that 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) maintain organizational practices to meet the needs of Black, Indigenous, and people of color communities, LGBTQ+ communities, and other underrepresented or marginalized communities. Organizational practices may include board and staff training, service offerings, advocacy efforts, and culturally informed outreach and services;

(9) use recovery-friendly language in all media and written materials that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma;

(10) establish and maintain a publicly available recovery community organization code of ethics and grievance policy and procedures;

(11) not classify or treat any recovery peer hired on or after July 1, 2024, as an independent contractor;

(12) not classify or treat any recovery peer as an independent contractor on or after January 1, 2025;

(13) provide an orientation for recovery peers that includes an overview of the consumer advocacy services provided by the Ombudsman for Mental Health and Developmental Disabilities and other relevant advocacy services; and

(14) provide notice to peer recovery support services participants that includes the following statement: "If you have a complaint about the provider or the person providing your peer recovery support services, you may contact the Minnesota Alliance of Recovery Community Organizations. You may also contact the Office of Ombudsman for Mental Health and Developmental Disabilities." The statement must also include:

(i) the telephone number, website address, email address, and mailing address of the Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(ii) the recovery community organization's name, address, email, telephone number, and name or title of the person at the recovery community organization to whom problems or complaints may be directed; and

(iii) a statement that the recovery community organization will not retaliate against a peer recovery support services participant because of a complaint.

(e) A recovery community organization approved by the commissioner before June 30, 2023, must have begun the application process as required by an approved certifying or accrediting entity and have begun the process to meet the requirements under paragraph (d) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(f) A recovery community organization that is aggrieved by an accreditation, certification, 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 (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (d), the recovery community organization is an eligible vendor of peer recovery support services.

(g) All recovery community organizations must be certified or accredited by an entity listed in paragraph (d) by June 30, 2025.

(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.

(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 254A.19, subdivision 3, 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.

(j) Any complaints about a recovery community organization or peer recovery support services may be made to and reviewed or investigated by the ombudsperson for behavioral health and developmental disabilities under sections 245.91 and 245.94.

Sec. 35. Minnesota Statutes 2024, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site whenever a client is present;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(d) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

(e) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

(f) A vendor that is not licensed as a residential treatment program must have a policy to address staffing coverage when a client may unexpectedly need to be present at the room and board site.

(g) No new vendors for room and board services may be approved after June 30, 2025, to receive payments from the behavioral health fund, under the provisions of section 254B.04, subdivision 2a. Room and board vendors that were approved and operating prior to July 1, 2025, may continue to receive payments from the behavioral health fund for services provided until June 30, 2027. Room and board vendors providing services in accordance with section 254B.04, subdivision 2a, will no longer be eligible to claim reimbursement for room and board services provided on or after July 1, 2027.

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

Sec. 36. Minnesota Statutes 2024, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** The commissioner shall allocate ~~77.05~~ 50 percent of patient payments and third-party payments to the special revenue account and ~~22.95~~ 50 percent to the county financially responsible for the patient.

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

Sec. 37. Minnesota Statutes 2024, section 254B.09, subdivision 2, is amended to read:

Subd. 2. **American Indian agreements.** The commissioner may enter into agreements with federally recognized Tribal units to pay for substance use disorder treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how the governing body of the Tribal unit fulfills ~~local agency~~ the Tribal unit's responsibilities regarding the form and manner of invoicing.

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

Sec. 38. Minnesota Statutes 2024, section 254B.181, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) All recovery residences must be certified by the commissioner in accordance with the standards of a National Alliance for Recovery Residences Level 1 or Level 2 recovery residence.

(b) All ~~sober homes~~ recovery residences must:

(1) comply with applicable state laws and regulations and local ordinances related to maximum occupancy, fire safety, and sanitation~~. In addition, all sober homes must:~~;

(2) have safety policies and procedures that at a minimum address:

(i) safety inspections requiring periodic verification of smoke detectors, carbon monoxide detectors, and fire extinguishers, and emergency evacuation drills;

(ii) exposure to bodily fluids and contagious diseases; and

(iii) emergency procedures posted in conspicuous locations in the residence;

~~(1)~~ (3) maintain a supply of an opiate antagonist in the home ~~in a conspicuous location and~~, post information on proper use, and train staff on how to administer the opiate antagonist;

~~(2)~~ (4) have written policies regarding access to all prescribed medications and storage of medications when requested by a resident;

~~(3)~~ (5) have written policies regarding ~~evictions~~ residency termination that include how length of stay is determined and eviction procedures;

~~(4)~~ (6) 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;

(7) ensure separation of funds of persons served by the program from funds of the program or program staff. The program and staff must not:

(i) borrow money from a person served by the program;

(ii) purchase personal items from a person served by the program;

(iii) sell merchandise or personal services to a person served by the program;

(iv) require a person served by the program to purchase items for which the program is eligible for reimbursement; or

(v) use funds of persons served by the program to purchase items for which the program is already receiving public or private payments;

~~(5)~~ (8) 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)~~ (9) maintain contact information for emergency resources in the community to address mental health and health emergencies;

~~(7)~~ (10) have policies on staff qualifications and prohibition against fraternization;

~~(8)~~ (11) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the United States Food and Drug Administration for the treatment of opioid use disorder;

~~(9)~~ (12) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the United States Food and Drug Administration to treat co-occurring substance use disorders and mental health conditions;

~~(10)~~ (13) have a fee schedule and refund policy;

~~(11)~~ (14) have rules for residents, including on any prohibited items;

~~(12)~~ (15) have policies that promote resident participation in treatment, self-help groups, or other recovery supports;

~~(13)~~ (16) have policies requiring abstinence from alcohol and illicit drugs on the property. If the program utilizes drug screening or toxicology, the procedures must be included in policy; ~~and~~

~~(14)~~ (17) distribute and post in the common areas the ~~sober home~~ resident bill of rights~~.~~, resident rules, and grievance process;

(18) have policies and procedures on searches;

(19) have code of ethics policies and procedures that are aligned with the National Alliance for Recovery Residences code of ethics and document that the policies and procedures are read and signed by every individual associated with the operation of the recovery residence, including owners, operators, staff, and volunteers;

(20) have a description of how residents are involved with the governance of the residence, including decision-making procedures, how residents are involved in setting and implementing rules, and the role of peer leaders, if any; and

(21) have procedures to maintain a respectful environment, including appropriate action to stop intimidation, bullying, sexual harassment, or threatening behavior of residents, staff, and visitors within the residence. Programs must consider trauma-informed and resilience-promoting practices when determining action.

Sec. 39. Minnesota Statutes 2024, section 254B.181, subdivision 2, is amended to read:

Subd. 2. **Bill of rights.** An individual living in a ~~sober home~~ recovery residence has the right to:

(1) have access to an environment that supports recovery;

(2) have access to an environment that is safe and free from alcohol and other illicit drugs or substances;

(3) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act, sections 626.557 to 626.5572;

(4) be treated with dignity and respect and to have personal property treated with respect;

(5) have personal, financial, and medical information kept private and to be advised of the ~~sober home's~~ recovery residence's policies and procedures regarding disclosure of such information;

(6) access, while living in the residence, to other community-based support services as needed;

(7) be referred to appropriate services upon leaving the residence, if necessary;

(8) retain personal property that does not jeopardize safety or health;

(9) assert these rights personally or have them asserted by the individual's representative or by anyone on behalf of the individual without retaliation;

(10) be provided with the name, address, and telephone number of the ombudsman for mental health~~, substance use disorder,~~ and developmental disabilities and the certifying designated state affiliate and information about the right to file a complaint;

(11) be fully informed of these rights and responsibilities, as well as program policies and procedures; and

(12) not be required to perform services for the residence that are not included in the usual expectations for all residents.

Sec. 40. Minnesota Statutes 2024, section 254B.181, subdivision 3, is amended to read:

Subd. 3. **Complaints~~; ombudsman for mental health and developmental disabilities.~~** Any complaints about a ~~sober home~~ recovery residence may be made to and reviewed or investigated by the ombudsman for mental health and developmental disabilities, pursuant to sections 245.91 and 245.94, and the certifying designated state affiliate.

Sec. 41. Minnesota Statutes 2024, section 254B.181, is amended by adding a subdivision to read:

Subd. 5. **Resident records.** (a) A recovery residence must maintain documentation for each resident of a written agreement prior to beginning residency that includes the following:

(1) the resident bill of rights;

(2) financial obligations and agreements, refund policy, and payments from third party payers for any fees paid on the resident's behalf;

(3) services provided;

(4) recovery goals;

(5) relapse policies; and

(6) policies on personal property.

(b) A recovery residence must maintain documentation for each resident demonstrating:

(1) completion of orientation on emergency procedures;

(2) completion of orientation on resident rules;

(3) that the resident is formally linked with the community, such as the resident maintaining or searching for a job, being enrolled in an education program, or working with family services or health and housing programs;

(4) that residents and staff engage in community relations and interactions to promote kinship with other recovery communities and goodwill for recovery services; and

(5) any referrals made for additional services.

(c) Resident records are private data on individuals as defined in section 13.02, subdivision 12.

Sec. 42. Minnesota Statutes 2024, section 254B.181, is amended by adding a subdivision to read:

Subd. 6. **Staff requirements.** Certified level 2 programs must have staff to model and teach recovery skills and behaviors and must have the following policies and procedures:

(1) written job descriptions for each staff member position, including position responsibilities and qualifications;

(2) performance plans for development of staff in need of improvement;

(3) a staffing plan that demonstrates continuous development for all staff;

(4) background checks for all staff who will have direct and regular interaction with residents;

(5) expectations for staff to maintain clear personal and professional boundaries;

(6) annual trainings on emergency procedures, the resident bill of rights, grievance policies and procedures, and the code of ethics; and

(7) a prohibition on staff providing billable peer recovery support services to residents of the recovery residence.

Sec. 43. **[254B.182] RECOVERY RESIDENCE CERTIFICATION.**

(a) Effective January 1, 2027, the commissioner of human services shall certify all recovery residences in Minnesota that are in compliance with section 254B.181. Beginning

January 1, 2027, a recovery residence may not serve clients without a certification from the commissioner.

(b) The commissioner shall:

(1) publish a list of certified recovery residences, including any data related to date of certification, contact information, compliance reports, and the results of any investigations. The facts of any investigation that substantiates an adverse impact on an individual's health or safety is public information, except for any identifying information on a resident or complainant;

(2) make requirements for certification of recovery residences publicly accessible;

(3) review and recertify recovery residences every three years;

(4) compile an annual report on the number of recovery residences, the number of newly certified recovery residences in the last year, and the number of recovery residences that lost certification in the last year;

(5) review and make certification determinations for all recovery residences beginning on July 1, 2027; and

(6) make a certification determination for a recovery residence within 90 days of application.

(c) The commissioner may decertify a recovery residence with a 30-day notice.

(d) A recovery residence that is not certified or is decertified may request reconsideration. The recovery residence must appeal a denial or decertification in writing and send or deliver the reconsideration request to the commissioner by certified mail, by personal service, or through the provider licensing and reporting hub. If the recovery residence mails the reconsideration request, the reconsideration request must be postmarked and sent to the commissioner within ten calendar days after the recovery residence receives the order of certification denial or decertification. If the recovery residence delivers a reconsideration request by personal service, the commissioner must receive the reconsideration request within ten calendar days after the recovery residence received the order. If the order is issued through the provider hub, the request must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. If a recovery residence submits a timely reconsideration request of an order of certification denial or decertification, the recovery residence may continue to operate the program until the commissioner issues a final order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Sec. 44. Minnesota Statutes 2024, section 254B.19, subdivision 1, is amended to read:

Subdivision 1. **Level of care requirements.** (a) 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~~ psychosocial 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~~ Ancillary services and treatment coordination may be provided beyond the hourly ~~skilled~~ psychosocial 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~~ psychosocial 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~~ Ancillary services and treatment coordination may be provided beyond the hourly ~~skilled~~ psychosocial 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~~ psychosocial treatment services. Services must be licensed according to section 245G.20 ~~and must meet requirements under section 256B.0759~~. Level 2.5 is for clients who need daily monitoring in a structured setting, as directed by the individual treatment plan and in accordance with the limitations in section 254B.05, subdivision 5, paragraph (h). If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs must provide at least 5 hours of ~~skilled~~ psychosocial 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~~ psychosocial treatment services seven days a week according to each client's specific treatment schedule, as directed by the individual treatment plan.

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

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

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

(b) Notwithstanding the minimum daily ~~skilled~~ psychosocial treatment service requirements under paragraph (a), clauses (6) and (7), ASAM level 3.3 and 3.5 vendors must provide each client at least 30 hours of treatment services per week for the period between January 1, 2024, through June 30, 2024.

Sec. 45. Minnesota Statutes 2024, section 256.043, subdivision 3, is amended to read:

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

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

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

(d) $2,000,000 is appropriated to the commissioner of human services for ~~grants~~ direct payments to Tribal nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce. Any evaluations of practices under this paragraph must be designed cooperatively by the commissioner and Tribal nations or urban Indian communities. The commissioner must not require recipients to provide the details of specific ceremonies or identities of healers.

(e) $400,000 is appropriated to the commissioner of human services for competitive grants for opioid-focused Project ECHO programs.

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

(g) $3,000,000 in fiscal year 2025 and $3,000,000 each year thereafter is appropriated to the commissioner of human services for safe recovery sites start-up and capacity building grants under section 254B.18.

(h) $395,000 in fiscal year 2024 and $415,000 each year thereafter is appropriated to the commissioner of human services for the opioid overdose surge alert system under section 245.891.

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

(j) $261,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (n).

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

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

(m) After the appropriations in paragraphs (b) to (l) are made, 50 percent of the remaining amount is appropriated to the commissioner of children, youth, and families for distribution

to county social service agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide prevention and child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to county social service agencies and Tribal social service agency initiative projects through a formula based on intake data from the previous three calendar years related to substance use and out-of-home placement episodes where parental drug abuse is a reason for the out-of-home placement. County social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide prevention and child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

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

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

(p) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs (c), (d), (e), (g), (m), and (n) are available for three years after the funds are appropriated.

Sec. 46. Minnesota Statutes 2024, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

(b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735, subdivision 3, shall be established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services. For CCBHCs certified after September 31, 2020, and before January 1, 2021, the commissioner shall rebase rates according to this clause for services provided on or after January 1, 2024;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System

(MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC certified under section 245.735 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision ~~2~~ 2a, paragraph (b), clause ~~(8)~~ (2).

Sec. 47. Minnesota Statutes 2024, section 256B.0757, subdivision 4c, is amended to read:

Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a licensed nurse, as defined in section 148.171, subdivision 9.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional who is qualified according to section 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner who is qualified according to section 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

(2) a mental health certified family peer specialist who is qualified according to section 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section ~~245G.07, subdivision 1, clause (5)~~ 245G.11, subdivision 8; or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

Sec. 48. Minnesota Statutes 2024, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph ~~(b)~~ (c), an agency may not enter into an agreement with an establishment to provide housing support unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed

under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02, subdivision 4a, as a community residential setting by the commissioner of human services; or

(3) the facility is licensed under chapter 144G and provides three meals a day.

(b) Effective January 1, 2027, the commissioner may enter into housing support agreements with a board and lodging establishment under section 256I.04, subdivision 2a, paragraph (a), clause (1), that is also certified by the commissioner as a recovery residence, subject to the requirements of section 256I.04, subdivisions 2a to 2f. When doing so, the department of human services serves as the lead agency for the agreement.

~~(b)~~ (c) The requirements under paragraph (a) do not apply to establishments exempt from state licensure because they are:

(1) located on Indian reservations and subject to tribal health and safety requirements; or

(2) supportive housing establishments where an individual has an approved habitability inspection and an individual lease agreement.

~~(c)~~ (d) Supportive housing establishments that serve individuals who have experienced long-term homelessness and emergency shelters must participate in the homeless management information system and a coordinated assessment system as defined by the commissioner.

~~(d)~~ (e) Effective July 1, 2016, an agency shall not have an agreement with a provider of housing support unless all staff members who have direct contact with recipients:

(1) have skills and knowledge acquired through one or more of the following:

(i) a course of study in a health- or human services-related field leading to a bachelor of arts, bachelor of science, or associate's degree;

(ii) one year of experience with the target population served;

(iii) experience as a mental health certified peer specialist according to section 256B.0615; or

(iv) meeting the requirements for unlicensed personnel under sections 144A.43 to 144A.483;

(2) hold a current driver's license appropriate to the vehicle driven if transporting recipients;

(3) complete training on vulnerable adults mandated reporting and child maltreatment mandated reporting, where applicable; and

(4) complete housing support orientation training offered by the commissioner.

Sec. 49. Minnesota Statutes 2024, section 325F.725, is amended to read:

325F.725 ~~SOBER HOME~~ RECOVERY RESIDENCE TITLE PROTECTION.

No person or entity may use the phrase ~~"sober home,"~~ "recovery residence," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity meets the definition of a ~~sober home~~ recovery residence in section 254B.01, subdivision 11, and meets the requirements of section 254B.181.

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

Sec. 50. **WORKING GROUP FOR RECOVERY RESIDENCES.**

(a) The commissioner of human services must convene a working group on recovery residences.

(b) The working group must:

(1) produce a report that examines how other states fund recovery residences, identifying best practices and models that could be applicable to Minnesota;

(2) engage with communities to ensure meaningful collaboration with key external partners on the ideas being developed that will inform the final plan and recommendations; and

(3) develop an implementable plan addressing housing needs for individuals in outpatient substance use disorder treatment that includes:

(i) clear strategies for aligning housing models with individual treatment needs;

(ii) an assessment of funding streams, including potential federal funding sources;

(iii) a timeline for implementation, with key milestones and action steps;

(iv) recommendations for future resource allocation to ensure long-term housing stability for individuals in recovery; and

(v) specific recommendations for policy or legislative changes that may be required to support sustainable recovery housing solutions.

(c) The working group shall include but is not limited to:

(1) at least two designees from the Department of Human Services, at least one representing behavioral health policy and at least one representing homelessness, housing and support services policy;

(2) the commissioner of health or a designee;

(3) two people who have experience living in a recovery residence;

(4) representatives from at least three substance use disorder lodging facilities currently operating in Minnesota;

(5) three representatives from county social services agencies, at least one from within and one from outside the seven-county metropolitan area;

(6) a representative from a Tribal social services agency; and

(7) representatives from national or state organizations specializing in recovery residences and substance use disorder treatment.

(d) The working group shall meet at least monthly and as necessary to fulfill its responsibilities. The commissioner of human services shall provide administrative support and meeting space for the working group. The working group may conduct meetings remotely.

(e) The commissioner of human services shall make appointments to the working group by October 1, 2025, and convene the first meeting of the working group by January 15, 2026.

(f) The working group shall submit a final report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before January 1, 2027.

Sec. 51. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the terms "mental health practitioner" and "mental health practitioners" to "behavioral health practitioner" or "behavioral health practitioners" wherever they appear in Minnesota Statutes, chapter 245I.

Sec. 52. **REPEALER.**

(a) Minnesota Statutes 2024, sections 245G.01, subdivision 20d; 245G.07, subdivision 2; and 254B.01, subdivision 5, are repealed.

(b) Minnesota Statutes 2024, section 254B.04, subdivision 2a, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2025, and paragraph (b) is effective July 1, 2027.

ARTICLE 5
HEALTH CARE

Section 1. Minnesota Statutes 2024, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the commissioner shall review all medical evidence and seek information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Medical assistance providers must grant the state medical review team access to electronic health records held by the medical assistance providers, when available, to support efficient and accurate disability determinations.

~~(b)~~ (c) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

~~(c)~~ (d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not

issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Sec. 2. Minnesota Statutes 2024, section 256B.04, subdivision 12, is amended to read:

Subd. 12. **Limitation on services.** (a) The commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(1) an opportunity for all recognized transportation providers to be reimbursed for nonemergency transportation consistent with the maximum rates established by the agency; and

(2) reimbursement of public and private nonprofit providers serving the population with a disability generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner. This

paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(d) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service.

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

Sec. 3. Minnesota Statutes 2024, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements;

(6) drugs; and

(7) quitline services as described in section 256B.0625, subdivision 68, paragraph (c).

This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, when determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C to provide items under the medical assistance program, including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment; and

(viii) electronic diagnostic, therapeutic, and life-support systems;

(5) nonemergency medical transportation; and

(6) drugs.

~~(b)~~ (c) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

~~(c)~~ (d) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(e) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for incontinence products and related supplies.

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

Sec. 4. Minnesota Statutes 2024, section 256B.0625, subdivision 17, is amended to read:

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

(b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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

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

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

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

(4) public transportation, within the meaning of "public transportation" as defined in section 174.22, subdivision 7; or

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

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

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

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

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

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

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

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

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

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

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

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(g) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid medical assistance, the administrative agency of nonemergency medical transportation must:

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

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

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

~~(g)~~ (h) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph ~~(l)~~ (n), clauses (4), (5), (6), and (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(h)~~ (i) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

~~(i)~~ (j) Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(k) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, nonemergency medical transportation providers must take clients to the health care provider using the most direct route and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the administrator.

~~(j)~~ (l) Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical

transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

~~(k)~~ (m) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

~~(l)~~ (n) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

~~(m)~~ (o) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph ~~(l)~~ (n) according to paragraphs ~~(p) and (q)~~

(r) to (t) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(n)~~ (p) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

~~(o)~~ (q) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(p)~~ (r) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(k)~~ (m), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(s) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (m), not the type of vehicle used to provide the service.

~~(q)~~ (t) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph ~~(p)~~ (r), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph ~~(p)~~ (r), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph ~~(p)~~ (r), clauses (1) to (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(r)~~ (u) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs ~~(p) and (q)~~ (r) to (t), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(s)~~ (v) The commissioner, when determining reimbursement rates for nonemergency medical transportation ~~under paragraphs (p) and (q)~~, shall exempt all modes of transportation listed under paragraph ~~(l)~~ (n) from Minnesota Rules, part 9505.0445, item R, subitem (2).

~~(t)~~ (w) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(p)~~ (r) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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

Sec. 5. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18i. **Administration of nonemergency medical transportation.** Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner must contract either statewide or regionally for the administration of the nonemergency medical transportation program in compliance with the provisions of this chapter. The contract must include the administration of the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

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

Sec. 6. **REPEALER.**

Minnesota Statutes 2024, section 256B.0625, subdivisions 18b, 18e, and 18h, are repealed.

EFFECTIVE DATE. This section is effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

ARTICLE 6
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 144.0724, subdivision 11, is amended to read:

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone or be homeless without the person's current housing and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraphs (b) and (c), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28, that occurred no more than ~~60~~ one calendar ~~days~~ year before the effective date of medical assistance eligibility for payment of long-term care services.

Sec. 2. Minnesota Statutes 2024, section 256.01, subdivision 34, is amended to read:

Subd. 34. **Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

(1) reimbursement for the Minnesota senior health options project; ~~and~~

(2) reimbursement related to prior authorization, review of medical necessity, and inpatient admission certification by a professional review organization. A portion of these

funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance.; and

(3) reimbursement for capacity building and implementation grant expenditures for the medical assistance reentry demonstration waiver under section 256B.0761.

ARTICLE 7

DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of human services and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

		APPROPRIATIONS Available for the Year Ending June 30	
		2026	**2027**
Sec. 2. **TOTAL APPROPRIATION**	**$**	**5,225,959,000**	**$** **5,133,590,000**

Subdivision 1. **Appropriations by Fund**

Appropriations by Fund		
	2026	2027
General	5,204,101,000	5,131,732,000
Lottery Prize	1,733,000	1,733,000
State Government Special Revenue	125,000	125,000
Family and Medical Benefit Insurance	20,000,000	-0-

The amounts that may be spent for each purpose are specified in the following sections.

Subd. 2. **Information Technology Appropriations**

(a) **IT Appropriations Generally**

This appropriation includes funds for information technology projects, services, and

support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs must be incorporated into the service-level agreement and paid to Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for Systems Project**

Appropriations and federal receipts for information technology systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services deems necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Sec. 3. **CENTRAL OFFICE; OPERATIONS** **$ 4,315,000 $ 4,836,000**

The general fund base for this section is $3,196,000 in fiscal year 2028 and $3,010,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE** **$ 3,358,000 $ 3,871,000**

Sec. 5. **CENTRAL OFFICE; AGING AND DISABILITY SERVICES** **$ 52,510,000 $ 51,498,000**

Subdivision 1. **Appropriations by Fund**

	2026	2027
General	52,385,000	51,373,000
State Government Special Revenue	125,000	125,000

Subd. 2. **Residential Overnight Staffing Reform Study**

$250,000 in fiscal year 2026 is to complete a study on residential overnight staffing reform. This is a onetime appropriation.

Subd. 3. **Base Level Adjustment**

The general fund base for this section is $50,701,000 in fiscal year 2028 and $50,701,000 in fiscal year 2029.

Sec. 6. **CENTRAL OFFICE; BEHAVIORAL HEALTH** **$ 735,000 $ 686,000**

$150,000 in fiscal year 2026 is for a workgroup on recovery residences. This is a onetime appropriation and is available until June 30, 2027.

Sec. 7. **CENTRAL OFFICE; HOMELESSNESS, HOUSING, AND SUPPORT SERVICES** **$ -0- $ 276,000**

The general fund base for this section is $321,000 in fiscal year 2028 and $321,000 in fiscal year 2029.

Sec. 8. **CENTRAL OFFICE; OFFICE OF INSPECTOR GENERAL** **$ 8,883,000 $ 11,330,000**

The general fund base for this section is $11,476,000 in fiscal year 2028 and $11,476,000 in fiscal year 2029.

Sec. 9. **FORECASTED PROGRAMS; HOUSING SUPPORT** **$ -0- $ 1,800,000**

Sec. 10. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE** **$ 4,766,244,000 $ 4,734,694,000**

Sec. 11. **FORECASTED PROGRAMS; ALTERNATIVE CARE** **$ 74,000 $ 186,000**

Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Sec. 12. **FORECASTED PROGRAMS; BEHAVIORAL HEALTH FUND** **$ 114,251,000 $ 107,822,000**

Sec. 13. **GRANT PROGRAMS; OTHER LONG-TERM CARE GRANTS** **$ 22,747,000 $ 1,925,000**

Subdivision 1. **Appropriations by Fund**

	2026	2027
General	2,747,000	1,925,000
Family and Medical Benefit Insurance	20,000,000	.....

Subd. 2. **Direct Care Provider Premiums Through HCBS Workforce Incentive Fund**

(a) $20,000,000 in fiscal year 2026 is from the family and medical benefit account to the commissioner of human services to provide reimbursement for premiums incurred for the paid family and medical leave program under this chapter. Funds must be administered through the home and community-based workforce incentive fund under Minnesota Statutes, section 256.4764.

(b) The commissioner of employment and economic development shall share premium payment data collected under this chapter to assist the commissioner of human services in the verification process of premiums paid under this section.

(c) The amount in this subdivision is for the purposes of Minnesota Statutes, section 256.4764. This is a onetime appropriation and is available until June 30, 2027.

Sec. 14. **GRANT PROGRAMS; AGING AND ADULT SERVICES GRANTS** **$ 33,861,000 $ 33,862,000**

Sec. 15. **DEAF, DEAFBLIND, AND HARD OF HEARING GRANTS** **$ 2,886,000 $ 2,886,000**

Sec. 16. **GRANT PROGRAMS; DISABILITY GRANTS** **$ 64,030,000 $ 25,853,000**

Subdivision 1. **Self-Directed Bargaining Agreement; Orientation Start-Up Funds**

$3,000,000 in fiscal year 2026 is for orientation program start-up costs as defined by the SEIU collective bargaining agreement. This is a onetime appropriation.

Subd. 2. **Self-Directed Bargaining Agreement; Orientation Ongoing Funds**

$2,000,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are for ongoing costs related to the orientation program as defined by the SEIU collective bargaining agreement. The base for this appropriation is $500,000 in fiscal year 2028 and $500,000 in fiscal year 2029.

Subd. 3. **Self-Directed Bargaining Agreement; Training Stipends**

$2,250,000 in fiscal year 2026 is for onetime stipends of $750 for collective bargaining unit members for training. This is a onetime appropriation.

Subd. 4. **Self-Directed Bargaining Agreement; Retirement Trust Funds**

$350,000 in fiscal year 2026 is for a vendor to create a retirement trust, as defined by the SEIU collective bargaining agreement. This is a onetime appropriation.

Subd. 5. **Self-Directed Bargaining Agreement; Health Care Stipends**

$30,750,000 in fiscal year 2026 is for stipends of $1,200 for collective bargaining unit members for retention and defraying any health insurance costs they may incur. Stipends are available once per fiscal year per member for fiscal year 2026 and fiscal year 2027. Of this amount, $30,000,000 in fiscal year 2026 is for stipends and $750,000 in fiscal year 2026 is for administration. This is a onetime appropriation and is available until June 30, 2027.

Sec. 17. **GRANT PROGRAMS; ADULT MENTAL HEALTH GRANTS** **$ 110,217,000 $ 110,217,000**

Sec. 18. **GRANT PROGRAMS; CHILDREN'S MENTAL HEALTH GRANTS** **$ 34,648,000 $ 34,648,000**

Sec. 19. **GRANT PROGRAMS; CHEMICAL DEPENDENCY TREATMENT SUPPORT GRANTS** **$ 4,980,000 $ 4,980,000**

Appropriations by Fund

	2026	2027
General	3,247,000	3,247,000
Lottery Prize	1,733,000	1,733,000

Sec. 20. **GRANT PROGRAMS; HIV GRANTS** **$ 2,220,000 $ 2,220,000**

Sec. 21. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2025, within fiscal years among general assistance, medical assistance, MinnesotaCare, the Minnesota supplemental aid program, the housing support program, and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioners deem necessary, with the advance approval of the commissioner of management and budget. The commissioners shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Subd. 3. **Children, youth, and families.** Administrative money may be transferred between the Department of Human Services and the Department of Children, Youth, and Families as the commissioners deem necessary, with the advance approval of the commissioner of management and budget. The commissioners shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over children and families quarterly about transfers made under this section.

ARTICLE 8

DIRECT CARE AND TREATMENT APPROPRIATIONS

Section 1. **DIRECT CARE AND TREATMENT APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the executive board of direct care and treatment and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **EXECUTIVE BOARD OF DIRECT CARE AND TREATMENT; TOTAL APPROPRIATION**	**$ 577,328,000**	**$ 602,021,000**
The amounts that may be spent for each purpose are specified in the following sections.		
Sec. 3. **MENTAL HEALTH AND SUBSTANCE ABUSE**	**$ 189,761,000**	**$ 194,840,000**
Sec. 4. **COMMUNITY-BASED SERVICES**	**$ 13,927,000**	**$ 14,170,000**
Sec. 5. **FORENSIC SERVICES**	**$ 160,239,000**	**$ 164,094,000**

Sec. 6. **SEX OFFENDER PROGRAM**	**$**	**128,050,000**	**$**	**131,351,000**
Sec. 7. **ADMINISTRATION**	**$**	**85,351,000**	**$**	**97,566,000**

Sec. 8. **TRANSFER AUTHORITY.**

(a) Money appropriated for budget programs in sections 3 to 7 may be transferred between budget programs and between years of the biennium with the approval of the commissioner of management and budget.

(b) The executive board of Direct Care and Treatment, with the approval of the commissioner of management and budget, may transfer money appropriated for Direct Care and Treatment administration into the special revenue account for security systems and information technology projects, services, and support.

(c) Positions, salary money, and nonsalary administrative money may be transferred within and between Direct Care and Treatment and the Department of Human Services as the executive board and commissioner consider necessary, with the advance approval of the commissioner of management and budget.

ARTICLE 9

OTHER AGENCY APPROPRIATIONS

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

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

		APPROPRIATIONS Available for the Year Ending June 30		
		2026		**2027**
Sec. 2. **COUNCIL ON DISABILITY**	**$**	**2,432,000**	**$**	**2,457,000**
Sec. 3. **OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$**	**3,706,000**	**$**	**3,765,000**

APPENDIX
Article locations for 25-00339

144A.1888 REUSE OF FACILITIES.

Notwithstanding any local ordinance related to development, planning, or zoning to the contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or changes operations shall be considered a conforming use permitted under local law, provided that the facility is converted to another long-term care service approved by a regional planning group under section 256R.40 that serves a smaller number of persons than the number of persons served before the closure or curtailment, reduction, or change in operations.

245G.01 DEFINITIONS.

Subd. 20d. **Skilled treatment services.** "Skilled treatment services" has the meaning provided in section 254B.01, subdivision 10.

245G.07 TREATMENT SERVICE.

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner;

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

(8) peer recovery support services must be provided by a recovery peer qualified according to section 245I.04, subdivision 18. Peer recovery support services must be provided according to sections 254B.05, subdivision 5, and 254B.052.

254B.01 DEFINITIONS.

Subd. 5. **Local agency.** "Local agency" means the agency designated by a board of county commissioners, a local social services agency, or a human services board authorized under section 254B.03, subdivision 1, to determine financial eligibility for the behavioral health fund.

254B.04 ELIGIBILITY FOR BEHAVIORAL HEALTH FUND SERVICES.

Subd. 2a. **Eligibility for room and board services for persons in outpatient substance use disorder treatment.** A person eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), must score at level 4 on assessment dimensions related to readiness to change, relapse, continued use, or recovery environment in order to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

256B.0625 COVERED SERVICES.

Subd. 18b. **Broker dispatching prohibition.** Except for establishing level of service process, the commissioner shall not use a broker or coordinator for any purpose related to nonemergency medical transportation services under subdivision 18.

Subd. 18e. **Single administrative structure and delivery system.** The commissioner, in coordination with the commissioner of transportation, shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the

date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The web-based single administrative structure shall operate on a trial basis for one year from implementation and, if approved by the commissioner, shall be permanent thereafter.

Subd. 18h. **Nonemergency medical transportation provisions related to managed care.** (a) The following nonemergency medical transportation (NEMT) subdivisions apply to managed care plans and county-based purchasing plans:

(1) subdivision 17, paragraphs (a), (b), (i), and (n);

(2) subdivision 18; and

(3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

(c) Managed care plans and county-based purchasing plans must provide a fuel adjustment for NEMT rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

256B.434 PAYMENT RATES AND PROCEDURES; CONTRACTS AND AGREEMENTS.

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, 2019, a nursing facility's property payment rate for the second and subsequent years of a facility's contract under this section are the previous rate year's property payment rate plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

256R.02 DEFINITIONS.

Subd. 38. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on December 31, 2015, under Minnesota Rules and Minnesota Statutes, inclusive of health insurance, plus property insurance costs from external fixed costs, minus any rate increases allowed under Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 55a.

256R.12 COST ALLOCATION.

Subd. 10. **Allocation of self-insurance costs.** For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health, dental, or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this chapter. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly

allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or those self-insurance costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its group health, dental, or life insurance self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs.

256R.23 TOTAL CARE-RELATED PAYMENT RATES.

Subd. 6. **Payment rate limit reduction.** No facility shall be subject in any rate year to a care-related payment rate limit reduction greater than five percent of the median determined in subdivision 4.

256R.36 HOLD HARMLESS.

No nursing facility's operating payment rate, plus its employer health insurance costs portion of the external fixed costs payment rate, will be less than its prior system operating cost payment rate.

256R.40 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility or the date that beds from a partial closure are delicensed and decertified.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. **Applications for planned closure rate.** (a) To be considered for approval of a planned closure, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan designed to comply with section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided; and

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

(b) The application must also address the criteria listed in subdivision 3.

Subd. 3. **Criteria for review of application.** In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area. The facility shall indicate in its application the service area it believes is appropriate for this measurement;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 4. **Review and approval of applications.** (a) The commissioner, in consultation with the commissioner of health, shall approve or deny an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner unless commencement of closure has begun.

(c) The commissioner may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs immediately following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

Subd. 6. **Assignment of closure rate to another facility.** A facility or facilities reimbursed under this chapter with a closure plan approved by the commissioner under subdivision 4 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 5. Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 5, unless they: (1) are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater; (2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and (3) have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 5 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 5, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 5, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that delicensed beds is located.

Subd. 7. **Other rate adjustments.** Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under this chapter.

256R.41 SINGLE-BED ROOM INCENTIVE.

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first day of the month of January or July, whichever occurs first following the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

256R.481 RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.

(a) The commissioner shall allow each nonprofit nursing facility located within the boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once annually for a rate add-on to the facility's external fixed costs payment rate.

(b) A facility seeking an add-on to its external fixed costs payment rate under this section must apply annually to the commissioner to receive the add-on. A facility must submit the application within 60 calendar days of the effective date of any add-on under this section. The commissioner may waive the deadlines required by this paragraph under extraordinary circumstances.

(c) The commissioner shall provide the add-on to each eligible facility that applies by the application deadline.

(d) The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for case mix classification PA1 of the nonprofit facilities located in an adjacent city in another state and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment rate for case mix classification PA1 as determined under section 256R.22, subdivision 4.

256R.53 FACILITY SPECIFIC EXEMPTIONS.

Subdivision 1. **Nursing facility in Golden Valley.** The operating payment rate for a facility located in the city of Golden Valley at 3915 Golden Valley Road with 44 licensed rehabilitation beds as of January 7, 2015, is the sum of its direct care costs per standardized day, its other care-related costs per resident day, and its other operating costs per day.