..... moves to amend H.F. No. 2847 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

DISABILITY SERVICES

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

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

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

Sec. 2. Minnesota Statutes 2022, section 179A.54, is amended by adding a subdivision to read:

Subd. 11. **Home Care Orientation 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 Home Care Orientation Trust, for the exclusive purpose of rendering voluntary orientation training to individual providers of direct support services who are represented by the exclusive representative.

(b) Financial contributions made by the state to the Home Care Orientation Trust shall be made pursuant to a collective bargaining agreement negotiated under this section. All such financial contributions made by the state shall be held in trust for the purpose of paying from principle, from interest, or from both, the costs associated with developing, delivering, and promoting voluntary orientation training for individual providers of direct support services working under a collective bargaining agreement and providing services through a covered program under section 256B.0711. The Home Care Orientation Trust shall be administered, managed, and otherwise controlled jointly by a board of trustees composed of an equal number of trustees appointed by the state and trustees appointed by the exclusive representative under this section. The trust shall not be an agent of either the state or the exclusive representative.

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

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

(e) Financial contributions to, and participation in, the administration and management of the Home Care Orientation Trust shall not be considered an unfair labor practice under section 179A.13, or a violation of Minnesota law.

Sec. 3. **[245.996] POSITIVE SUPPORTS PROVIDER TRAINING AND ENDORSEMENT SYSTEM.**

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

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

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

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

Sec. 4. Minnesota Statutes 2022, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a family child foster care home or family adult foster care home license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings where at least 80 percent of the residents are 55 years of age or older;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity

of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital-level care; or

(5) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 or elderly waiver plan under chapter 256S and residing in the customized living setting ~~before July 1, 2022,~~ for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until ~~June 30~~ December 31, 2023. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people ~~under the brain injury or community access for disability inclusion waiver plans under section 256B.49~~ in a single-family home operational on or before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

(ii) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(iii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the customized living setting as determined by the lead agency.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately

inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available data required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

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

Sec. 5. Minnesota Statutes 2022, section 245A.10, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(3) the alternative method of providing overnight supervision, which may include the use of technology, is specified for each resident in the resident's: (i) individualized plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if required; or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required.

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

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

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

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

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

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

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

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

(b) Applications for a license under this section must be submitted directly to the Department of Human Services licensing division. The licensing division must immediately notify the county licensing agency. The licensing division must collaborate with the county licensing agency in the review of the application and the licensing of the program.

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

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

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

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

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

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

(i) a description of the triggering incident;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Each resident's placement agreement, individual service agreement, and plan must clearly state that the adult foster care ~~or community residential setting~~ license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to the health, safety, or rights of residents served by the program under paragraph (e), clause (1) or (2); and a signed informed consent from each resident served by the program or the person's legal representative documenting the person's or legal representative's agreement with

placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2022, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services;

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

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

(3) residential supports and services, including:

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

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

child foster care residence, a family adult foster care residence, or a community residential setting;

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

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

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

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

(4) day services, including:

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

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

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

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

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

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

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

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

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

Sec. 9. **[245D.261] COMMUNITY RESIDENTIAL SETTINGS; REMOTE OVERNIGHT SUPERVISION.**

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

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

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

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

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

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

(1) use enabling technology;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2022, section 252.44, is amended to read:

252.44 LEAD AGENCY BOARD RESPONSIBILITIES.

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

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

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

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

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

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

Sec. 11. **[252.54] STATEWIDE DISABILITY EMPLOYMENT TECHNICAL ASSISTANCE CENTER.**

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

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

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

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

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

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

Sec. 12. **[252.55] LEAD AGENCY EMPLOYMENT FIRST CAPACITY BUILDING GRANTS.**

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

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

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

(3) other activities approved by the commissioner.

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

Sec. 13. **[256.4761] PROVIDER CAPACITY GRANTS FOR RURAL AND UNDERSERVED COMMUNITIES.**

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

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

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

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

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

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

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

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

(1) expanding existing services;

(2) increasing access in rural or underserved areas;

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

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

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

Sec. 14. Minnesota Statutes 2022, section 256.482, is amended by adding a subdivision to read:

Subd. 9. **Report to the legislature.** On or before January 15, 2025, and annually on January 15 thereafter, the Minnesota Council on Disability shall submit a report to the chair and ranking minority members of the legislative committees with jurisdiction over state government finance and local government specifying the number of cities and counties that received training or technical assistance on website accessibility, the outcomes of website accessibility training and outreach, the costs incurred by cities and counties to make website accessibility improvements, and any other information that the council deems relevant.

Sec. 15. Minnesota Statutes 2022, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member

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

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

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

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

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

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

(6) a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person ~~and the person's spouse~~ in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded liquid assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more

before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. ~~The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7.~~ Persons eligible under this clause are not subject to the provisions in section 256B.059; and

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

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

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

Sec. 16. Minnesota Statutes 2022, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2022, section 256B.0659, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other

essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the recipient's personal care assistance care plan.

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

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

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

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

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2022, section 256B.0659, subdivision 12, is amended to read:

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

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

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

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

(2) provider name and telephone numbers;

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

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

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2022, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2022, section 256B.0911, subdivision 13, is amended to read:

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

(b) MnCHOICES certified assessors must:

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

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

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

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

Sec. 22. Minnesota Statutes 2022, section 256B.092, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

(ii) employment service providers;

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

(iv) providers of financial management services;

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

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

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

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

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

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the person-centered support plan and habilitation plan.

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

identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ~~ten~~ 20 hours of case management education and disability-related training each year. The education and training must include person-centered planning, informed choice, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner. For case managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers must document completion of training in a system identified by the commissioner of human services.

Sec. 23. Minnesota Statutes 2022, section 256B.0949, subdivision 15, is amended to read:

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

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

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

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

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

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

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

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

(iii) a board-certified behavior analyst; or

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

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

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

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

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

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

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

(2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2022, section 256B.49, subdivision 13, is amended to read:

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

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

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

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

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

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

(iii) employment service providers;

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

(v) providers of financial management services;

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

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

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

(1) finalizing the person-centered support plan;

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

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

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

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

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ~~ten~~ 20 hours of case management education and disability-related training each year. The education and training must include person-centered planning, informed choice, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner. For case managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers shall document completion of training in a system identified by the commissioner of human services.

Sec. 25. Minnesota Statutes 2022, section 256B.4905, subdivision 4a, is amended to read:

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

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

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

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

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

Sec. 26. **[256B.4906] SUBMINIMUM WAGES IN HOME AND COMMUNITY-BASED SERVICES PROHIBITION; REQUIREMENTS.**

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

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

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

(b) The report required under paragraph (a) must include the following data about each individual being paid subminimum wages required under paragraph (a):

(1) name;

(2) date of birth;

(3) identified race and ethnicity;

(4) disability type;

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

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

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

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

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

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

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

Sec. 27. Minnesota Statutes 2022, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) life sharing;

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

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

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

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

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

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

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

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

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

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

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

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

(2) on ~~November~~ January 1, 2024, based on wage data by SOC from the Bureau of Labor Statistics ~~available as of December 31, 2021~~ published in March 2022; and

(3) on ~~July 1, 2026~~ January 1, 2026, and every two years thereafter, based on wage data by SOC from the Bureau of Labor Statistics ~~available 30 months and one day~~ published in March, 22 months prior to the scheduled update.

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

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

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

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

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

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

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

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

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

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

29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

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

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

(8) for positive supports analyst staff, 100 percent of the median wage for substance abuse, behavioral disorder, and mental health counselor (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 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

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

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

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

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

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

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

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

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

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

(3) on ~~July 1, 2026~~ January 1, 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 30 months and one day prior to the scheduled update.

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

Sec. 31. Minnesota Statutes 2022, section 256B.4914, subdivision 6, is amended to read:

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

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

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

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

Sec. 32. Minnesota Statutes 2022, section 256B.4914, subdivision 10a, is amended to read:

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

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

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

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

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

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

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

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

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

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

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

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

(d) Compensation under this subdivision includes:

(1) wages;

(2) taxes and workers' compensation;

(3) health insurance;

(4) dental insurance;

(5) vision insurance;

(6) life insurance;

(7) short-term disability insurance;

(8) long-term disability insurance;

(9) retirement spending;

(10) tuition reimbursement;

(11) wellness programs;

(12) paid vacation time;

(13) paid sick time; or

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

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

Sec. 34. Minnesota Statutes 2022, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

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

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

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

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

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

(d) Exception requests must include the following information:

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

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

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

(4) any contingencies for approval.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision to read:

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

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

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

Sec. 37. Minnesota Statutes 2022, section 256B.851, subdivision 3, is amended to read:

Subd. 3. **Payment rates; base wage index.** When initially establishing the base wage component values, the commissioner must use the Minnesota-specific median wage for the standard occupational classification (SOC) codes published by the Bureau of Labor Statistics in the edition of the Occupational Handbook ~~available January 1,~~ published in March 2021. The commissioner must calculate the base wage component values as follows for:

(1) personal care assistance services, CFSS, extended personal care assistance services, and extended CFSS. The base wage component value equals the median wage for personal care aide (SOC code 31-1120);

(2) enhanced rate personal care assistance services and enhanced rate CFSS. The base wage component value equals the product of median wage for personal care aide (SOC code 31-1120) and the value of the enhanced rate under section 256B.0659, subdivision 17a; and

(3) qualified professional services and CFSS worker training and development. The base wage component value equals the sum of 70 percent of the median wage for registered nurse (SOC code 29-1141), 15 percent of the median wage for health care social worker (SOC code 21-1099), and 15 percent of the median wage for social and human service assistant (SOC code 21-1093).

EFFECTIVE DATE. This section is effective January 1, 2024, or within 90 days of federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2022, section 256B.851, subdivision 5, is amended to read:

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

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

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

(3) employee benefits factor, 12.04 percent;

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

(5) program plan support factor, 7.00 percent;

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

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

(8) absence and utilization factor, 3.90 percent.

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

(1) personal care assistance services and CFSS: ~~75.45~~ 88.66 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: ~~75.45~~ 88.66 percent; and

(3) qualified professional services and CFSS worker training and development: ~~75.45~~ 88.66 percent.

(c) 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.

(d) 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 0.0 percent;

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

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

EFFECTIVE DATE. The amendments to paragraph (b) are effective January 1, 2024, or within 90 days of federal approval, whichever is later. Paragraph (b) expires January 1, 2025, or within 90 days of federal approval of paragraph (c), whichever is later. Paragraphs (c) to (e) are effective January 1, 2025, or within 90 days of federal approval, whichever is

later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 39. Minnesota Statutes 2022, section 256B.851, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

(b) In processing 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).

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

EFFECTIVE DATE. This section is effective January 1, 2025, or within 90 days of federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 40. Minnesota Statutes 2022, section 256D.425, subdivision 1, is amended to read:

Subdivision 1. **Persons entitled to receive aid.** A person who is aged, blind, or 18 years of age or older and disabled and who is receiving supplemental security benefits under Title XVI on the basis of age, blindness, or disability (or would be eligible for such benefits except for excess income) is eligible for a payment under the Minnesota supplemental aid program, if the person's net income is less than the standards in section 256D.44. A person who is receiving benefits under the Minnesota supplemental aid program in the month prior to becoming eligible under section 1619(b) of the Social Security Act is eligible for a payment under the Minnesota supplemental aid program while they remain in section 1619(b) status. Persons who are not receiving Supplemental Security Income benefits under Title XVI of the Social Security Act or disability insurance benefits under Title II of the Social Security Act due to exhausting time limited benefits are not eligible to receive benefits under the MSA program. Persons who are not receiving Social Security or other maintenance benefits for failure to meet or comply with the Social Security or other maintenance program requirements are not eligible to receive benefits under the MSA program. Persons who are found ineligible for Supplemental Security Income because of excess income, but whose income is within the limits of the Minnesota supplemental aid program, must have blindness or disability determined by the state medical review team.

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

Sec. 41. Minnesota Statutes 2022, section 268.19, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 42. Laws 2021, First Special Session chapter 7, article 17, section 16, is amended to read:

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

(a) This act includes $400,000 in fiscal year 2022 and $300,000 in fiscal year 2023 for an actuarial research study of public and private financing options for long-term services and supports reform to increase access across the state. Any unexpended amount in fiscal year 2023 is available through June 30, 2024. The commissioner of human services must

conduct the study. Of this amount, the commissioner may transfer up to $100,000 to the commissioner of commerce for costs related to the requirements of the study. The general fund base included in this act for this purpose is $0 in fiscal year 2024 and $0 in fiscal year 2025.

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

Sec. 43. **HOME AND COMMUNITY-BASED WORKFORCE INCENTIVE FUND GRANTS.**

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

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

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

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

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

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

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

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

(1) retention, recruitment, and incentive payments;

(2) postsecondary loan and tuition payments;

(3) child care costs;

(4) transportation-related costs; and

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

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

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

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

(1) the employer is an eligible employer;

(2) the total number of eligible employees;

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

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

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

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

Subd. 5. **Distribution plan; report.** (a) A provider agency or individual provider that receives a grant under subdivision 4 shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive and how that money will be distributed for recruitment and retention purposes for eligible employees. Within 60 days of receiving the grant, the provider must post the distribution plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access.

(b) Within 12 months of receiving a grant under this section, each provider agency or individual provider that receives a grant under subdivision 4 shall submit a report to the commissioner that includes the following information:

(1) a description of how grant funds were distributed to eligible employees; and

(2) the total dollar amount distributed.

(c) Failure to submit the report under paragraph (b) may result in recoupment of grant funds.

Subd. 6. **Audits and recoupment.** (a) The commissioner may perform an audit under this section up to six years after a grant is awarded to ensure:

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

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

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

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

Subd. 7. **Grants not to be considered income.** (a) For the purposes of this subdivision, "subtraction" has the meaning given in Minnesota Statutes, section 290.0132, subdivision 1, paragraph (a), and the rules in that subdivision apply to this subdivision. The definitions in Minnesota Statutes, section 290.01, apply to this subdivision.

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

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

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

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

(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 and diversionary work program under Minnesota Statutes, chapter 256J; and

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

(e) The commissioner must not consider grant awards 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.

Sec. 44. **NEW AMERICAN LEGAL AND SOCIAL SERVICES WORKFORCE GRANT PROGRAM.**

Subdivision 1. **Definition.** "Eligible workers" means persons who require legal services to seek or maintain status and secure or maintain legal authorization for employment.

Subd. 2. **Grant program established.** The commissioner of human services shall establish a new American legal and social services workforce grant program for organizations that assist eligible workers:

(1) in seeking or maintaining legal or citizenship status to become or remain legally authorized for employment in any field or industry, including, but not limited to, the long-term care workforce;

(2) to provide supports during the legal process or while seeking qualified legal assistance.

Subd. 3. **Distribution of grants.** The commissioner shall ensure that grant funds are awarded to organizations and entities that demonstrate that they have the qualifications, experience, expertise, cultural competency, and geographic reach to offer legal or social services under this section to eligible workers. In distributing grant awards, the commissioner shall prioritize organizations or entities serving populations for whom existing legal services and social services for the purposes listed in subdivision 2 are unavailable or insufficient.

Subd. 4. **Eligible grantees.** Organizations or entities eligible to receive grant funding under this section include local governmental units, federally recognized Tribal Nations, and nonprofit organizations as defined under section 501(c)(3) of the Internal Revenue Code that provide legal or social services to eligible populations. Priority should be given to organizations and entities that serve populations in areas of the state where worker shortages are most acute.

Subd. 5. **Grantee duties.** Organizations or entities receiving grant funding under this section must provide services that include the following activities:

(1) intake, assessment, referral, orientation, legal advice, or representation to eligible workers to seek or maintain legal or citizenship status and secure or maintain legal authorization for employment in the United States; or

(2) social services designed to help eligible populations meet their immediate basic needs during the process of seeking or maintaining legal status and legal authorization for employment, including but not limited to accessing housing, food, employment or employment training, education, course fees, community orientation, transportation, child care, and medical care. Social services may also include navigation services to address

ongoing needs once immediate basic needs have been met and repaying student loan debt directly incurred as a result of pursuing a qualifying course of study or training.

Subd. 6. **Reporting.** (a) Grant recipients under this section must collect and report to the commissioner information on program participation and program outcomes. The commissioner shall determine the form and timing of reports.

(b) Grant recipients providing immigration legal services under this section must collect and report to the commissioner data that is consistent with the requirements established for the Supreme Court by the advisory committee under section 480.242, subdivision 1.

Sec. 45. **EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION LICENSURE STUDY.**

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

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

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

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

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

Sec. 46. **STUDY TO EXPAND ACCESS TO SERVICES FOR PEOPLE WITH CO-OCCURRING BEHAVIORAL HEALTH CONDITIONS AND DISABILITIES.**

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

Sec. 47. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

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

Sec. 48. **MEMORANDUMS OF UNDERSTANDING.**

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

Sec. 49. **SPECIALIZED EQUIPMENT AND SUPPLIES LIMIT INCREASE.**

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

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

Sec. 50. **INTERAGENCY EMPLOYMENT SUPPORTS ALIGNMENT STUDY.**

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

(1) service rates;

(2) provider enrollment and monitoring standards; and

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

Sec. 51. **MONITORING EMPLOYMENT OUTCOMES.**

By January 15, 2025, the Departments of Human Services, Employment and Economic Development, and Education must provide the chairs and ranking minority members of the legislative committees with jurisdiction over health, human services, and labor with a plan for tracking employment outcomes for people with disabilities served by programs

administered by the agencies. This plan must include any needed changes to state law to track supports received and outcomes across programs.

Sec. 52. **PHASE-OUT OF THE USE OF SUBMINIMUM WAGE FOR MEDICAL ASSISTANCE DISABILITY SERVICES.**

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

Sec. 53. **RATE INCREASE FOR CERTAIN DISABILITY WAIVER SERVICES.**

The commissioner of human services shall increase payment rates for chore services, homemaker services, and home-delivered meals provided under Minnesota Statutes, sections 256B.092 and 256B.49, by 15.8 percent from the rates in effect on December 31, 2023.

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

Sec. 54. **RATE INCREASE FOR EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT SERVICES.**

The commissioner of human services shall increase payment rates for early intensive developmental and behavioral intervention services under Minnesota Statutes, section 256B.0949, by 15.8 percent from the rates in effect on December 31, 2023.

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

Sec. 55. **RATE INCREASE FOR HOME CARE SERVICES.**

The commissioner of human services shall increase payment rates for home health services and home care nursing services under Minnesota Statutes, section 256B.0651, subdivision 2, clauses (1) and (3), respiratory therapy under Minnesota Rules, part 9505.0295, subpart 2, item (E), and home health agency services under Minnesota Statutes, section 256B.0653, by 15.8 percent from the rates in effect on December 31, 2023.

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

Sec. 56. **RATE INCREASE FOR INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES DAY TRAINING AND HABILITATION SERVICES.**

The commissioner of human services shall increase payment rates for day training and habilitation services under Minnesota Statutes, section 252.46, by 15.8 percent from the rates in effect on December 31, 2023.

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

Sec. 57. **STUDY ON PRESUMPTIVE ELIGIBILITY FOR LONG-TERM SERVICES AND SUPPORTS.**

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

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

(2) home and community-based services.

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

(1) current eligibility processes;

(2) barriers to timely eligibility determinations; and

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

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

Sec. 58. **SYSTEMIC REVIEW OF ACUTE CARE HOSPITALIZATIONS STUDY.**

(a) The commissioner of human services must conduct a systemic review of acute care hospitalizations for people on medical assistance with disabilities, behavioral health conditions, and older adults. The review must include:

(1) an analysis of reimbursement rates to support people with complex support needs;

(2) a survey of other states' policies, models, and service options to reduce and respond to acute care hospitalizations;

(3) systemic critical incident reviews of people who are hospitalized in acute care hospitals for longer than 90 days in order to determine systemic, regulatory, staff training, or other reoccurring barriers keeping individuals from returning to the community or lower levels of care; and

(4) a comparison of different methods to increase and enhance statewide provider capacity to support people with complex needs.

(b) The commissioner must submit a report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by January 15, 2025. The report must include proposed legislation necessary to enact the report's recommendations.

Sec. 59. **REPEALER.**

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

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

ARTICLE 2
AGING SERVICES

Section 1. Minnesota Statutes 2022, section 256.975, subdivision 6, is amended to read:

Subd. 6. ~~**Indian**~~ **Native American elders coordinator position.** (a) The Minnesota Board on Aging shall create ~~an Indian~~ a Native American elders coordinator position~~,~~ and shall hire staff as appropriations permit for the purposes of ~~coordinating efforts with the National Indian Council on Aging and developing~~ facilitating the coordination and development of a ~~comprehensive~~ statewide Tribal-based service system for ~~Indian~~ Native

American elders. ~~An Indian elder is defined for purposes of this subdivision as an Indian enrolled in a band or tribe who is 55 years or older.~~

(b) For purposes of this subdivision, the following terms have the meanings given:

(1) "Native American elder" means an individual enrolled in a federally recognized Tribe and identified as an elder according to the requirements of the individual's home Tribe; and

(2) "Tribal government" means representatives of each of the 11 federally recognized Native American Tribes located wholly or partially within the boundaries of the state of Minnesota.

(c) The statewide Tribal-based service system ~~must~~ may include the following components:

~~(1) an assessment of the program eligibility, examining the need to change the age-based eligibility criteria to need-based eligibility criteria;~~

~~(2)~~ (1) a ~~planning system that would~~ plan to grant, or make recommendations for granting, federal and state funding for statewide Tribal-based Native American programs and services;

(2) a plan to develop business initiatives involving Tribal members that will qualify for federal- and state-funded elder service contracts;

(3) a plan for statewide Tribal-based service focal points~~, senior centers, or community centers~~ for socialization and service accessibility for ~~Indian~~ Native American elders;

(4) a plan to develop and implement statewide education and public awareness ~~campaigns~~ promotions including ~~awareness programs, sensitivity~~ cultural sensitivity training~~,~~ and public education on ~~Indian elder needs~~ Native American elders;

(5) a plan for statewide culturally appropriate information and referral services for Native American elders including legal advice and counsel and trained advocates ~~and an Indian elder newsletter~~;

(6) a plan for a coordinated statewide Tribal-based health care system including health ~~promotion/prevention~~ promotion and prevention, in-home service, long-term care service, and health care services;

(7) a plan for ongoing ~~research involving Indian elders including needs assessment and needs analysis;~~ collection of significant data on Native American elders including population, health, socialization, mortality, homelessness, and economic status; and

~~(8) information and referral services for legal advice or legal counsel; and~~

~~(9)~~ (8) a plan to coordinate services with existing organizations, including but not limited to the state of Minnesota, the ~~Council of~~ Minnesota Indian Affairs Council, ~~the Minnesota Indian Council of Elders,~~ the Minnesota Board on Aging, Wisdom Steps, and Minnesota Tribal governments.

Sec. 2. Minnesota Statutes 2022, section 256.9754, is amended to read:

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

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

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

(b) "Core home and community-based services provider" means a Faith in Action, Living at Home/Block Nurse, congregational nurse, or similar community-based program governed by a board, the majority of whose members reside within the program's service area, that organizes and uses volunteers and paid staff to deliver nonmedical services intended to assist older adults to identify and manage risks and to maintain their community living and integration in the community.

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

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

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

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

(b) The purpose of projects selected by the commissioner of human services under this section is to make strategic changes in the long-term services and supports system for older

adults and people with dementia, including statewide capacity for local service development and technical assistance, and statewide availability of home and community-based services for older adult services, caregiver support and respite care services, and other supports in the state of Minnesota. These projects are intended to create incentives for new and expanded home and community-based services in Minnesota in order to:

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

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

(3) support the informal caregivers of older adults;

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

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

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

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

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

(9) strengthen programs that use volunteers.

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

Subd. 3. ~~**Provision of**~~ **Community services development grants.** The commissioner shall make community services development grants available to communities, providers of older adult services ~~identified in subdivision 1~~, or to a consortium of providers of older adult services, to establish older adult services. Grants may be provided for capital and other costs including, but not limited to, start-up and training costs, equipment, and supplies related to older adult services or other residential or service alternatives to nursing facility care. Grants may also be made to renovate current buildings, provide transportation services,

fund programs that would allow older adults or individuals with a disability to stay in their own homes by sharing a home, fund programs that coordinate and manage formal and informal services to older adults in their homes to enable them to live as independently as possible in their own homes as an alternative to nursing home care, or expand state-funded programs in the area.

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

Subd. 3b. **State waivers.** The commissioner of health may waive applicable state laws and rules for grantees under subdivision 3 on a time-limited basis if the commissioner of health determines that a participating grantee requires a waiver in order to achieve demonstration project goals.

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

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

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

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

(4) identify at-risk caregivers;

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

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

(b) Projects must clearly describe:

(1) how they will achieve their purpose;

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

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

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

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

(2) recruit and train volunteer providers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 5. **Grant preference.** The commissioner of human services shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. The commissioner may award grants to the extent grant funds are available and to the extent applications are approved by the commissioner. Denial of approval of an application in one year does not preclude submission of an application in a subsequent year. The maximum grant amount is limited to $750,000.

Sec. 3. **[256.9756] CAREGIVER RESPITE SERVICES GRANTS.**

Subdivision 1. **Caregiver respite services grant program established.** The commissioner of human services must establish a caregiver respite services grant program to increase the availability of respite services for family caregivers of people with dementia and older adults and to provide information, education, and training to respite caregivers and volunteers regarding caring for people with dementia. From the funds made available for this purpose, the commissioner must award grants on a competitive basis to respite service providers, giving priority to areas of the state where there is a high need of respite services.

Subd. 2. **Eligible uses.** Grant recipients awarded grant funding under this section must use a portion of the grant award as determined by the commissioner to provide free or subsidized respite services for family caregivers of people with dementia and older adults.

Subd. 3. **Report.** By January 15, 2026, and every other January 15 thereafter, the commissioner shall submit a progress report about the caregiver respite services grants in this section to the chairs and ranking minority members of the legislative committees with

jurisdiction over human services. The progress report must include metrics of the use of the grant program funds.

Sec. 4. Minnesota Statutes 2022, section 256B.0917, subdivision 1b, is amended to read:

Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

~~(b) "Community" means a town; township; city; or targeted neighborhood within a city; or a consortium of towns, townships, cities, or specific neighborhoods within a city.~~

~~(c) "Core home and community-based services provider" means a Faith in Action, Living at Home Block Nurse, Congregational Nurse, or similar community-based program governed by a board, the majority of whose members reside within the program's service area, that organizes and uses volunteers and paid staff to deliver nonmedical services intended to assist older adults to identify and manage risks and to maintain their community living and integration in the community.~~

~~(d)~~ (b) "Eldercare development partnership" means a team of representatives of county social service and public health agencies, the area agency on aging, local nursing home providers, local home care providers, and other appropriate home and community-based providers in the area agency's planning and service area.

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

~~(f)~~ (d) "Older adult" refers to an individual who is 65 years of age or older.

Sec. 5. Minnesota Statutes 2022, section 256M.42, is amended to read:

256M.42 ADULT PROTECTION GRANT ALLOCATIONS.

Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated under this section on an annual basis to each county board ~~and tribal government approved by the commissioner to assume county agency duties~~ for adult ~~protective services or as a lead investigative agency~~ protection under section 626.557 ~~on an annual basis in an amount determined~~ and to Tribal Nations that have voluntarily chosen by resolution of Tribal government to participate in vulnerable adult protection programs according to the following formula after the award of the amounts in paragraph (c):

(1) 25 percent must be allocated to the responsible agency on the basis of the number of reports of suspected vulnerable adult maltreatment under sections 626.557 and 626.5572, ~~when the county or tribe is responsible~~ as determined by the most recent data of the commissioner; and

(2) 75 percent must be allocated to the responsible agency on the basis of the number of screened-in reports for adult protective services or vulnerable adult maltreatment investigations under sections 626.557 and 626.5572, ~~when the county or tribe is responsible~~ as determined by the most recent data of the commissioner.

(b) ~~The commissioner is precluded from changing the formula under this subdivision or recommending a change to the legislature without public review and input.~~ Notwithstanding this subdivision, no county must be awarded less than a minimum allocation established by the commissioner.

(c) To receive money under this subdivision, a participating Tribal Nation must apply to the commissioner. Of the amount appropriated for purposes of this section, the commissioner must award $100,000 to each federally recognized Tribal Nation with a Tribal resolution establishing a vulnerable adult protection program. Money received by a Tribal Nation under this section must be used for its vulnerable adult protection program.

Subd. 2. **Payment.** The commissioner shall make allocations for the state fiscal year starting July 1, ~~2019~~ 2023, and to each county board or tribal government on or before October 10, ~~2019~~ 2023. The commissioner shall make allocations under subdivision 1 to each county board or tribal government each year thereafter on or before July 10.

Subd. 3. ~~**Prohibition on supplanting existing money**~~ **Purpose of expenditures.** Money received under this section must be used ~~for staffing for protection of vulnerable adults or~~ to meet the agency's duties under section 626.557 and to expand adult protective services to stop, prevent, and reduce risks of maltreatment for adults accepted for services under section . ~~Money must not be used to supplant current county or tribe expenditures for these purposes.~~

Subd. 4. **Required expenditures.** State funds must be used to expand, not supplant, county or Tribal expenditures for the fiscal year 2023 base for adult protection programs, service interventions, or multidisciplinary teams. This prohibition on county or Tribal expenditures supplanting state money ends July 1, 2027.

Subd. 5. **County performance on adult protection measures.** The commissioner must set vulnerable adult protection measures and standards for money received under this section. The commissioner must require an underperforming county to demonstrate that the county

designated money allocated under this section for the purpose required and implemented a reasonable strategy to improve adult protection performance, including the development of a performance improvement plan and additional remedies identified by the commissioner. The commissioner may redirect up to 20 percent of an underperforming county's money under this section toward the performance improvement plan.

Subd. 6. **American Indian adult protection.** Tribal Nations shall establish vulnerable adult protection measures and standards and report annually to the commissioner on these outcomes and the number of adults served.

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

Sec. 6. Minnesota Statutes 2022, section 256R.17, subdivision 2, is amended to read:

Subd. 2. **Case mix indices.** (a) The commissioner shall assign a case mix index to each case mix classification ~~based on the Centers for Medicare and Medicaid Services staff time measurement study~~ as determined by the commissioner of health under section 144.0724.

(b) An index maximization approach shall be used to classify residents. "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

Sec. 7. Minnesota Statutes 2022, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2022, section 256R.47, is amended to read:

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

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

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

(c) ~~The commissioner shall allow the benefits in clauses (1) to (5)~~ For nursing facilities designated as critical access nursing facilities~~:~~, the commissioner shall allow a supplemental payment above a facility's operating payment rate as determined to be necessary by the commissioner to maintain access to nursing facility services in isolated areas identified in paragraph (b). The commissioner must approve the amounts of supplemental payments through a memorandum of understanding. Supplemental payments to facilities under this section must be in the form of time-limited rate adjustments included in the external fixed costs payment rate under section 256R.25.

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2022, section 256S.211, is amended to read:

256S.211 RATE SETTING; ~~RATE ESTABLISHMENT~~ UPDATING RATES; EVALUATION; COST REPORTING.

Subdivision 1. **Establishing base wages.** When establishing the base wages according to section 256S.212, the commissioner shall use standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the edition of the Occupational Handbook published immediately prior to January 1, 2019, using Minnesota-specific wages taken from job descriptions.

Subd. 2. **~~Establishing~~ Updating rates.** ~~By January 1 of each year,~~ The commissioner shall ~~establish factors,~~ update component rates~~,~~ and rates effective January 1, 2024, according to sections ~~256S.213 and~~ 256S.212 to 256S.215, using the factor and base wages ~~established according to section 256S.212~~ values the commissioner used to establish rates effective January 1, 2019.

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

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

(1) wages and salaries;

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

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

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

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

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

Subd. 4. **Evaluation of rate setting.** (a) Beginning January 1, 2024, and every two years thereafter, the commissioner, in consultation with stakeholders, shall use all available data and resources to evaluate the following rate setting elements:

(1) the base wage index;

(2) the factors and supervision wage components; and

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

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

Subd. 5. **Cost reporting.** (a) As determined by the commissioner, in consultation with stakeholders, a provider enrolled to provide services with rates determined under this chapter must submit requested cost data to the commissioner to support evaluation of the rate methodologies in this chapter. Requested cost data may include but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

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

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

EFFECTIVE DATE. Subdivision 4 is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Subdivision 5 is effective January 1, 2025.

Sec. 10. Minnesota Statutes 2022, section 256S.214, is amended to read:

256S.214 RATE SETTING; ADJUSTED BASE WAGE.

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

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

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

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

(b) If the base wage described in paragraph (a) is below $16.96, the base wage shall equal $16.96.

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

Sec. 11. Minnesota Statutes 2022, section 256S.215, subdivision 15, is amended to read:

Subd. 15. **Home-delivered meals rate.** The home-delivered meals rate ~~equals $9.30~~ is the rate in effect on July 1, 2023, adjusted by 16.28 percent. The commissioner shall increase the home delivered meals rate every July 1 by the percent increase in the nursing facility dietary per diem using the two most recent and available nursing facility cost reports.

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

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

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

The Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall: (1) work to advance age-friendly policies; and (2) coordinate state, local, and

private partners' collaborative work on emergency preparedness, with a focus on older adults, communities, and persons in zip codes most impacted by the COVID-19 pandemic. The Governor's Council on an Age-Friendly Minnesota is extended and expires June 30, ~~2024~~ 2027.

Sec. 13. Laws 2021, First Special Session chapter 7, article 17, section 8, is amended to read:

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

Subdivision 1. **Age-friendly community grants.** (a) This act includes $0 in fiscal year 2022 and $875,000 in fiscal year 2023 for age-friendly community grants. The commissioner of human services, in collaboration with the Minnesota Board on Aging and the Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall develop the age-friendly community grant program to help communities, including cities, counties, other municipalities, tribes, and collaborative efforts, to become age-friendly communities, with an emphasis on structures, services, and community features necessary to support older adult residents over the next decade, including but not limited to:

(1) coordination of health and social services;

(2) transportation access;

(3) safe, affordable places to live;

(4) reducing social isolation and improving wellness;

(5) combating ageism and racism against older adults;

(6) accessible outdoor space and buildings;

(7) communication and information technology access; and

(8) opportunities to stay engaged and economically productive.

The general fund base in this act for this purpose is $875,000 in fiscal year 2024 ~~and $0~~, $1,000,000 in fiscal year 2025, $1,000,000 in fiscal year 2026, $875,000 in fiscal year 2027, and $0 in fiscal year 2028.

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

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

Subd. 2. **Technical assistance grants.** (a) This act includes $0 in fiscal year 2022 and $575,000 in fiscal year 2023 for technical assistance grants. The commissioner of human

services, in collaboration with the Minnesota Board on Aging and the Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall develop the age-friendly technical assistance grant program. The general fund base in this act for this purpose is $575,000 in fiscal year 2024 ~~and $0~~, $575,000 in fiscal year 2025, $575,000 in fiscal year 2026, $575,000 in fiscal year 2027, and $0 in fiscal year 2028.

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

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

Sec. 14. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; CAREGIVER RESPITE SERVICES GRANTS.**

Beginning in fiscal year 2025, the commissioner of human services must continue the respite services for older adults grant program established under Laws 2021, First Special Session chapter 7, article 17, section 17, subdivision 3, under the authority granted under Minnesota Statutes, section 256.9756. The commissioner may begin the grant application process for awarding grants under Minnesota Statutes, section 256.9756, during fiscal year 2024 in order to facilitate the continuity of the grant program during the transition from a temporary program to a permanent one.

Sec. 15. **DIRECTION TO THE COMMISSIONER; FUTURE PACE IMPLEMENTATION FUNDING.**

The commissioner of human services must work with stakeholders to develop recommendations for financing mechanisms to complete the actuarial work and cover the administrative costs of a program of all-inclusive care for the elderly (PACE). The commissioner must recommend a financing mechanism that could begin July 1, 2024. By December 15, 2023, the commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care funding on the commissioner's progress toward developing a recommended financing mechanism.

Sec. 16. **RATE INCREASE FOR CERTAIN HOME AND COMMUNITY-BASED SERVICES.**

The commissioner of human services shall increase payment rates for community living assistance and family caregiver services under Minnesota Statutes, sections 256B.0913 and 256B.0922, and chapter 256S by 15.8 percent from the rates in effect on December 31, 2023.

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

Sec. 17. **TEMPORARY GRANT FOR SMALL CUSTOMIZED LIVING PROVIDERS.**

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

Sec. 18. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the headnote in Minnesota Statutes, section 256B.0917, from "HOME AND COMMUNITY-BASED SERVICES FOR OLDER ADULTS" to "ELDERCARE DEVELOPMENT PARTNERSHIPS."

Sec. 19. **REPEALER.**

Minnesota Statutes 2022, section 256S.2101, subdivisions 1 and 2, are repealed.

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

ARTICLE 3
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 4.046, subdivision 6, is amended to read:

Subd. 6. **Office of Addiction and ~~recovery~~Recovery; director.** The Office of Addiction and Recovery is created in the Department of Management and Budget. The governor must appoint an addiction and recovery director, who shall serve as chair of the subcabinet and administer the Office of Addiction and Recovery. The director shall serve in the unclassified service and shall report to the governor. The director must:

(1) make efforts to break down silos and work across agencies to better target the state's role in addressing addiction, treatment, and recovery for youth and adults;

(2) assist in leading the subcabinet and the advisory council toward progress on measurable goals that track the state's efforts in combatting addiction for youth and adults, and preventing substance use and addiction among the state's youth population; and

(3) establish and manage external partnerships and build relationships with communities, community leaders, and those who have direct experience with addiction to ensure that all voices of recovery are represented in the work of the subcabinet and advisory council.

Sec. 2. Minnesota Statutes 2022, section 4.046, subdivision 7, is amended to read:

Subd. 7. **Staff and administrative support.** The commissioner of ~~human services~~ management and budget, in coordination with other state agencies and boards as applicable, must provide staffing and administrative support to the Office of Addiction and Recovery, the addiction and recovery director, the subcabinet, and the advisory council established in this section.

Sec. 3. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 4a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" has the meaning provided in section 254B.01, subdivision 2a.

Sec. 4. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 20c. **Protective factors.** "Protective factors" means the actions or efforts a person can take to reduce the negative impact of certain issues, such as substance use disorders, mental health disorders, and risk of suicide. Protective factors include connecting to positive supports in the community, a nutritious diet, exercise, attending counseling or 12-step groups, and taking appropriate medications.

Sec. 5. Minnesota Statutes 2022, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral,

diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 1a, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7); and 245G.17.

Sec. 6. Minnesota Statutes 2022, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** ~~(a)~~ A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within ~~three~~ five calendar days from the day of service initiation for a residential program or ~~within three calendar days on which a treatment session has been provided of the day of service initiation for a client~~ by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:~~

~~(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;~~

~~(2) a description of the circumstances on the day of service initiation;~~

~~(3) a list of previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;~~

~~(4) a list of substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and address the absence or presence of previous withdrawal symptoms;~~

~~(5) specific problem behaviors exhibited by the client when under the influence of substances;~~

~~(6) the client's desire for family involvement in the treatment program, family history of substance use and misuse, history or presence of physical or sexual abuse, and level of family support;~~

~~(7) physical and medical concerns or diagnoses, current medical treatment needed or being received related to the diagnoses, and whether the concerns need to be referred to an appropriate health care professional;~~

~~(8) mental health history, including symptoms and the effect on the client's ability to function; current mental health treatment; and psychotropic medication needed to maintain stability. The assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;~~

~~(9) arrests and legal interventions related to substance use;~~

~~(10) a description of how the client's use affected the client's ability to function appropriately in work and educational settings;~~

~~(11) ability to understand written treatment materials, including rules and the client's rights;~~

~~(12) a description of any risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;~~

~~(13) social network in relation to expected support for recovery;~~

~~(14) leisure time activities that are associated with substance use;~~

~~(15) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;~~

~~(16) whether the client recognizes needs related to substance use and is willing to follow treatment recommendations; and~~

~~(17) information from a collateral contact may be included, but is not required.~~

~~(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:~~

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

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

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

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

~~(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.~~

~~(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:~~

~~(1) the client is in severe withdrawal and likely to be a danger to self or others;~~

~~(2) the client has severe medical problems that require immediate attention; or~~

~~(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.~~

~~If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.~~ An alcohol and drug counselor must sign and date the comprehensive assessment review and update.

Sec. 7. Minnesota Statutes 2022, section 245G.05, is amended by adding a subdivision to read:

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

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

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

245.4863, except when the comprehensive assessment is being completed as part of a diagnostic assessment according to section;

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

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

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

(1) risks for opioid use disorder and dependence;

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

(3) the risk of and recognizing opioid overdose;

(4) the use, availability, and administration of naloxone to respond to opioid overdose; and

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

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

Sec. 8. Minnesota Statutes 2022, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program ~~and within five calendar days~~, by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The number of days to complete the individual treatment plan excludes the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect.

A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

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

Subd. 1a. **Individual treatment plan contents and process.** (a) After completing a client's comprehensive assessment, the license holder must complete an individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's comprehensive assessment;

(2) use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's individual treatment services, assessments, and treatment planning;

(3) identify the client's treatment goals in relation to any or all of the applicable ASAM six dimensions identified in section 254B.04, subdivision 4, to ensure measurable treatment objectives, a treatment strategy, and a schedule for accomplishing the client's treatment goals and objectives;

(4) document in the treatment plan the ASAM level of care identified in section 254B.05, subdivision 5, paragraph (b), clause (1), under which the client is receiving services;

(5) identify the participants involved in the client's treatment planning. The client must participate in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) identify resources to refer the client to when the client's needs will be addressed concurrently by another provider; and

(7) identify maintenance strategy goals and methods designed to address relapse prevention and to strengthen the client's protective factors.

Sec. 10. Minnesota Statutes 2022, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **Treatment plan review.** A treatment plan review must be ~~entered in a client's file weekly or after each treatment service, whichever is less frequent,~~ completed by the alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review ~~and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review~~, and must:

(1) ~~address each goal in the~~ document client goals addressed since the last treatment plan review and whether the identified methods ~~to address the goals are~~ continue to be effective;

(2) ~~include~~ document monitoring of any physical and mental health problems and include toxicology results for alcohol and substance use, when available;

(3) document the participation of others involved in the individual's treatment planning, including when services are offered to the client's family or significant others;

(4) if changes to the treatment plan are determined to be necessary, document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; ~~and~~

(5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65~~.~~; and

(6) document any referrals made since the previous treatment plan review.

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2022, section 245G.06, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

(7) service termination diagnosis.

Sec. 13. Minnesota Statutes 2022, section 245G.07, subdivision 2, is amended to read:

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner;

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

(8) peer recovery support services provided one-to-one by an individual in recovery qualified according to section ~~245G.11, subdivision 8~~ 245I.04, subdivision 18. Peer support services include education; advocacy; mentoring through self-disclosure of personal recovery experiences; attending recovery and other support groups with a client; accompanying the client to appointments that support recovery; assistance accessing resources to obtain housing, employment, education, and advocacy services; and nonclinical recovery support to assist the transition from treatment into the recovery community.

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

Sec. 14. Minnesota Statutes 2022, section 245G.09, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2022, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must ~~offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary~~ meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each time the client was offered an individual or group counseling service. If the individual or group counseling service was offered but not provided to the client, the license holder must document the

reason the service was not provided. If the service was provided, the license holder must ensure that the service is documented according to the requirements in section 245G.06, subdivision 2a .

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

~~(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:~~

~~(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;~~

~~(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated; and~~

~~(3)~~ (c) Notwithstanding the treatment plan review frequencies in section 245G.06, for the ten weeks following the day of service initiation for all new admissions, readmissions, and transfers, a weekly treatment plan review must be documented once the treatment plan is completed. Subsequently, the counselor must document treatment plan reviews in the six dimensions at least once monthly or, when clinical need warrants, more frequently.

Sec. 16. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, including withdrawal symptoms, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment; ~~and~~

(10) cultural influences on the client.; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

Sec. 17. Minnesota Statutes 2022, section 253B.10, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the

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

Sec. 18. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM" means the clinical guidelines for purposes of assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current edition of the *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*.

Sec. 19. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Skilled treatment services.** "Skilled treatment services" has the meaning given for the "treatment services" described in section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

Sec. 20. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Sober home.** A sober home is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that:

(1) provides temporary housing to persons with substance use disorders;

(2) stipulates that residents must abstain from using alcohol or other illicit drugs or substances not prescribed by a physician and meet other requirements as a condition of living in the home;

(3) charges a fee for living there;

(4) does not provide counseling or treatment services to residents; and

(5) promotes sustained recovery from substance use disorders.

Sec. 21. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 11. **Comprehensive assessment.** "Comprehensive assessment" means a person-centered, trauma-informed assessment that:

(1) is completed for a substance use disorder diagnosis, treatment planning, and determination of client eligibility for substance use disorder treatment services;

(2) meets the requirements in section 245G.05; and

(3) is completed by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5.

Sec. 22. Minnesota Statutes 2022, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) ~~outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~ those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to the following ASAM levels of care:

(i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1);

(ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2);

(iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);

(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4);

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5);

(vi) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6); and

(vii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7);

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) ~~care~~ treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) ~~on July 1, 2019, or upon federal approval, whichever is later,~~ withdrawal management services provided according to chapter 245F;

(6) substance use disorder treatment services with medications for opioid use disorder ~~that are~~ provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

~~(7) substance use disorder treatment with medications for opioid use disorder plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;~~

~~(9)~~ (7) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (8) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11) high-intensity residential treatment~~ (9) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide ~~30 hours of clinical services each week~~ ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and is provided

by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

~~(12)~~ (10) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

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

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

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

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

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

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

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

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

(ii) 25 percent of the counseling staff are licensed mental health professionals under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health

staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

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

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

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

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

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

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

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

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

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

Sec. 23. **[254B.17] WITHDRAWAL MANAGEMENT START-UP AND CAPACITY-BUILDING GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new withdrawal management programs that will meet medically monitored or clinically monitored levels of care. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

(5) costs associated with obtaining applicable and required licenses;

(6) business formation costs;

(7) costs associated with staff training; and

(8) the purchase of medical equipment and supplies necessary to meet health and safety requirements.

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

Sec. 24. **[254B.18] SOBER HOMES.**

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

(1) maintain a supply of naloxone in the home;

(2) have trained staff that can administer naloxone;

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

(4) have written policies regarding evictions;

(5) have staff training and policies regarding co-occurring mental illnesses;

(6) not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder and other medications with FDA-approved indications for the treatment of co-occurring disorders; and

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

Subd. 2. **Certification.** (a) The commissioner shall establish a certification program for sober homes. Certification is mandatory for sober homes receiving any federal, state, or local funding. The certification requirements must include:

(1) health and safety standards, including separate sleeping and bathroom facilities for people who identify as men and people who identify as women, written policies on how to accommodate residents who do not identify as a man or woman, and verification that the home meets fire and sanitation ordinances;

(2) intake admission procedures, including documentation of 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;

(3) an assessment of potential resident needs and appropriateness of the residence to meet these needs;

(4) a resident bill of rights, including a right to a refund if discharged;

(5) policies to address mental health and health emergencies, to prevent a person from hurting themselves or others, including contact information for emergency resources in the community;

(6) policies on staff qualifications and prohibition against fraternization;

(7) drug-testing procedures and requirements;

(8) policies to mitigate medication misuse, including policies for:

(i) securing medication;

(ii) house staff providing medication at specified times to residents;

(iii) medication counts with staff and residents;

(iv) storing and providing prescribed medications and documenting when a person accesses their prescribed medications; and

(v) ensuring that medications cannot be accessed by other residents;

(9) a policy on medications for opioid use disorder;

(10) having naloxone on site and in a conspicuous location;

(11) prohibiting charging exorbitant fees above standard costs for lab tests;

(12) discharge procedures, including involuntary discharge procedures that ensure at least a 24-hours notice prior to filing an eviction action. The notice must include the reasons for the involuntary discharge and a warning that an eviction action may become public as soon as it is filed, making finding future housing more difficult;

(13) a policy on referrals to substance use disorder treatment services, mental health services, peer support services, and support groups;

(14) training for staff on naloxone, mental health crises, de-escalation, person-centered planning, creating a crisis plan, and becoming a culturally informed and responsive sober home;

(15) a fee schedule and refund policy;

(16) copies of all forms provided to residents;

(17) rules for residents;

(18) background checks of staff and administrators;

(19) policies that promote recovery by requiring resident participation in treatment, self-help groups or other recovery supports; and

(20) policies requiring abstinence from alcohol and illicit drugs.

(b) Certifications must be renewed every three years.

Subd. 3. **Registry.** The commissioner shall create a registry containing a listing of sober homes that have met the certification requirements. The registry must include each sober home city and zip code, maximum resident capacity, and whether the setting serves a specific population based on race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Subd. 4. **Bill of rights.** An individual living in a sober home has the right to:

(1) access to an environment that supports recovery;

(2) access to an environment that is safe and free from alcohol and other illicit 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 policies and procedures regarding disclosure of such information;

(6) access, while living in the residence, to other community-based support services as needed;

(7) be referred to appropriate services upon leaving the residence, if necessary;

(8) retain personal property that does not jeopardize safety or health;

(9) assert these rights personally or have them asserted by the individual's representative or by anyone on behalf of the individual without retaliation;

(10) be provided with the name, address, and telephone number of the ombudsman for mental health, substance use disorder, and developmental disabilities and information about the right to file a complaint;

(11) be fully informed of these rights and responsibilities, as well as program policies and procedures; and

(12) not be required to perform services for the residence that are not included in the usual expectations for all residents.

Subd. 5. **Private right of action.** In addition to pursuing other remedies, an individual may bring an action to recover damages caused by a violation of this section. The court shall award a resident who prevails in an action under this section double damages, costs, disbursements, reasonable attorney fees, and any equitable relief the court deems appropriate.

Sec. 25. **[254B.19] AMERICAN SOCIETY OF ADDICTION MEDICINE STANDARDS OF CARE.**

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

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

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

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

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

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

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

(7) for ASAM level 3.5 clinically managed high-intensity residential clients, services must be licensed according to section 245G.20 and must meet requirements under section

256B.0759. Programs must have 24-hour staffing coverage and provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule, as directed by the individual treatment plan.

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

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

Subd. 2. **Patient referral arrangement agreement.** The license holder must maintain documentation of a formal patient referral arrangement agreement for each of the following ASAM levels of care not provided by the license holder:

(1) level 1.0 outpatient;

(2) level 2.1 intensive outpatient;

(3) level 2.5 partial hospitalization;

(4) level 3.1 clinically managed low-intensity residential;

(5) level 3.3 clinically managed population-specific high-intensity residential;

(6) level 3.5 clinically managed high-intensity residential;

(7) level withdrawal management 3.2 clinically managed residential withdrawal management; and

(8) level withdrawal management 3.7 medically monitored inpatient withdrawal management.

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

Subd. 4. **Program outreach plan.** Eligible vendors providing services under ASAM levels of care referenced in subdivision 1, clauses (2) to (7), must have a program outreach plan. The treatment director must document a review and update the plan annually. The program outreach plan must include treatment coordination strategies and processes to ensure seamless transitions across the continuum of care. The plan must include how the provider will:

(1) increase the awareness of early intervention treatment services, including but not limited to the services defined in section 254A.03, subdivision 3, paragraph (c);

(2) coordinate, as necessary, with certified community behavioral health clinics when a license holder is located in a geographic region served by a certified community behavioral health clinic;

(3) establish a referral arrangement agreement with a withdrawal management program licensed under chapter 245F when a license holder is located in a geographic region in which a withdrawal management program is licensed under chapter 245F. If a withdrawal management program licensed under chapter 245F is not geographically accessible, the plan must include how the provider will address the client's need for this level of care;

(4) coordinate with inpatient acute care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment;

(5) develop and maintain collaboration with local county and Tribal human services agencies; and

(6) collaborate with primary care and mental health settings.

Sec. 26. **[254B.20] EVIDENCE-BASED TRAINING.**

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

(1) ASAM criteria;

(2) person-centered and culturally responsive services;

(3) medical and clinical decision making;

(4) conducting assessments and appropriate level of care;

(5) treatment and service planning;

(6) identifying and overcoming systems challenges;

(7) conducting clinical case reviews; and

(8) appropriate and effective transfer and discharge.

Sec. 27. Minnesota Statutes 2022, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) ~~Outpatient~~ Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment ~~providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider~~ programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

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

~~(c)~~ (d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

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

~~(e)~~ (f) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must

consult with Tribal nations to discuss participation in the substance use disorder demonstration project.

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

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

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

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

Sec. 28. **FAMILY TREATMENT START-UP AND CAPACITY-BUILDING GRANTS.**

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

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

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

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

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

Sec. 29. **SAFE RECOVERY SITES START-UP AND CAPACITY-BUILDING GRANTS.**

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

(1) safe injection spaces;

(2) sterile needle exchange;

(3) naloxone rescue kits;

(4) fentanyl and other drug testing;

(5) street outreach;

(6) educational and referral services;

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

(8) access to hygiene and sanitation.

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

Sec. 30. **PUBLIC AWARENESS CAMPAIGN.**

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

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

(c) The campaign must include awareness-raising and educational information using multichannel marketing strategies, social media, virtual events, press releases, reports, and

targeted outreach. The commissioner must evaluate the effectiveness of the campaign and modify outreach and strategies as needed.

Sec. 31. **REVISED PAYMENT METHODOLOGY FOR OPIOID TREATMENT PROGRAMS.**

The commissioner of human services must revise the payment methodology for substance use services with medications for opioid use disorder under Minnesota Statutes, section 254B.05, subdivision 5, paragraph (b), clause (6). Payment must occur only if the provider renders the service or services billed on that date of service or, in the case of drugs and drug-related services, within a week as defined by the commissioner. The revised payment methodology must include a weekly bundled rate that includes the costs of drugs, drug administration and observation, drug packaging and preparation, and nursing time. The bundled weekly rate must be based on the Medicare rate. The commissioner must seek all necessary waivers, state plan amendments, and federal authorities required to implement the revised payment methodology.

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

Sec. 32. **MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY.**

The commissioner of human services, in consultation with stakeholders, must evaluate the feasibility, potential design, and federal authorities needed to cover traditional healing, behavioral health services in correctional facilities, and contingency management under the medical assistance program.

Sec. 33. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245G.01, subdivision 20b, as Minnesota Statutes, section 245G.01, subdivision 20d, and make any necessary changes to cross-references.

Sec. 34. **REPEALER.**

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

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

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

ARTICLE 4
OPIOID OVERDOSE PREVENTION AND OPIATE EPIDEMIC RESPONSE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subdivision 1. **Correctional facilities; inspection; licensing.** (a) Except as provided in paragraph (b), the commissioner of corrections shall inspect and license all correctional facilities throughout the state, whether public or private, established and operated for the detention and confinement of persons confined or incarcerated therein according to law except to the extent that they are inspected or licensed by other state regulating agencies. The commissioner shall promulgate pursuant to chapter 14, rules establishing minimum standards for these facilities with respect to their management, operation, physical condition, and the security, safety, health, treatment, and discipline of persons confined or incarcerated therein. These minimum standards shall include but are not limited to specific guidance pertaining to:

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

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

(3) suicide prevention plans and training;

(4) verification of medications in a timely manner;

(5) well-being checks;

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

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

(8) use of segregation and mental health checks;

(9) critical incident debriefings;

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

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

(12) a policy regarding the use of telehealth;

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

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

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

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

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

No individual, corporation, partnership, voluntary association, or other private organization legally responsible for the operation of a correctional facility may operate the facility unless it possesses a current license from the commissioner of corrections. Private adult correctional facilities shall have the authority of section 624.714, subdivision 13, if the Department of Corrections licenses the facility with the authority and the facility meets requirements of section 243.52.

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

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

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

All facility administrators of correctional facilities are required to report all deaths of individuals who died while committed to the custody of the facility, regardless of whether the death occurred at the facility or after removal from the facility for medical care stemming

from an incident or need for medical care at the correctional facility, as soon as practicable, but no later than 24 hours of receiving knowledge of the death, including any demographic information as required by the commissioner.

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

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

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

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

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

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

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

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

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

241.415 RELEASE PLANS; SUBSTANCE ABUSE.

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

Sec. 7. Minnesota Statutes 2022, section 245G.08, subdivision 3, is amended to read:

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

Sec. 8. Minnesota Statutes 2022, section 256.042, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 30 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

(1) two members of the house of representatives, appointed in the following sequence: the first from the majority party appointed by the speaker of the house and the second from the minority party appointed by the minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area, and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(2) two members of the senate, appointed in the following sequence: the first from the majority party appointed by the senate majority leader and the second from the minority party appointed by the senate minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota Medical Association;

(5) one member representing opioid treatment programs, sober living programs, or substance use disorder programs licensed under chapter 245G;

(6) one member appointed by the Minnesota Society of Addiction Medicine who is an addiction psychiatrist;

(7) one member representing professionals providing alternative pain management therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

(8) one member representing nonprofit organizations conducting initiatives to address the opioid epidemic, with the commissioner's initial appointment being a member representing the Steve Rummler Hope Network, and subsequent appointments representing this or other organizations;

(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

(10) one member representing the Minnesota courts who is a judge or law enforcement officer;

(11) one public member who is a Minnesota resident and who is in opioid addiction recovery;

(12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and one representing the Dakota tribes~~ each of Minnesota's Tribal Nations;

(13) two members representing urban American Indian populations;

~~(13)~~ (14) one public member who is a Minnesota resident and who is suffering from chronic pain, intractable pain, or a rare disease or condition;

~~(14)~~ (15) one mental health advocate representing persons with mental illness;

~~(15)~~ (16) one member appointed by the Minnesota Hospital Association;

~~(16)~~ (17) one member representing a local health department; and

~~(17)~~ (18) the commissioners of human services, health, and corrections, or their designees, who shall be ex officio nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity, and shall ensure that at least ~~one-half~~ one-third of council members appointed by the commissioner reside outside of the seven-county metropolitan area. Of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic.

(c) The council is governed by section 15.059, except that members of the council shall serve three-year terms and shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Sec. 9. Minnesota Statutes 2022, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 1 of each year, beginning December 1, 2022. This paragraph expires upon the expiration of the advisory council.

(b) The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (h), and subdivision 3a, paragraph (d). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration. The commissioner must award at least 50 percent of grants to projects that include a focus on addressing the opioid crisis in Black and Indigenous communities and communities of color.

Sec. 10. Minnesota Statutes 2022, section 256.043, subdivision 3, is amended to read:

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

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

(c) $100,000 is appropriated to the commissioner of human services for grants for 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 to Tribal nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce.

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

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

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2022, section 256.043, subdivision 3a, is amended to read:

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

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

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

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

(e) After making the appropriations in paragraphs (b), (c), and (d), the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042.

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

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

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

Sec. 12. **[256I.052] OPIATE ANTAGONISTS.**

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

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

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

Sec. 13. Laws 2019, chapter 63, article 3, section 1, as amended by Laws 2020, chapter 115, article 3, section 35, and Laws 2022, chapter 53, section 12, is amended to read:

Section 1. **APPROPRIATIONS.**

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

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

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

(d) **Commissioner of public safety; enforcement activities.** $672,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of public safety for the

Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

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

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

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

(h) **Commissioner of human services; traditional healing.** $2,000,000 in fiscal year 2020 is appropriated from the general fund and $2,000,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services to award grants to Tribal nations and five urban Indian communities for traditional healing practices to American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce. ~~The opiate epidemic response fund base for this appropriation is $2,000,000 in fiscal year 2022, $2,000,000 in fiscal year 2023, $2,000,000 in fiscal year 2024, and $0 in fiscal year 2025.~~

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

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

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

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

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

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

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

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

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

preference to proposals that incorporate innovative community partnerships, are informed and led by people in the community where the project is taking place, and are culturally relevant and delivered by culturally competent providers. This is a onetime appropriation.

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

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

Sec. 14. **OPIOID OVERDOSE SURGE ALERT SYSTEM.**

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

Sec. 15. **HARM REDUCTION AND CULTURALLY SPECIFIC GRANTS.**

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

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

(c) Culturally specific organizational capacity grant funds must be used to develop and improve organizational infrastructure to increase access to culturally specific services and community building. Allowable expenses include funds for organizations to hire staff or consultants who specialize in fundraising, grant writing, business development, and program integrity or other identified organizational needs as approved by the commissioner.

(d) Culturally specific service grant funds must be used to expand culturally specific outreach and services. Allowable expenses include hiring or consulting with cultural advisors, resources to support cultural traditions, and education to empower, develop a sense of community, and develop a connection to ancestral roots.

Sec. 16. **REPEALER.**

Minnesota Statutes 2022, section 256.043, subdivision 4, is repealed.

EFFECTIVE DATE. This section is effective July 1, 2023.

ARTICLE 5
OPIOID PRESCRIBING IMPROVEMENT PROGRAM

Section 1. Minnesota Statutes 2022, section 256B.0638, subdivision 1, is amended to read:

Subdivision 1. **Program established.** The commissioner of human services, in conjunction with the commissioner of health, shall coordinate and implement an opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers and to support patient-centered, compassionate care for Minnesotans who require treatment with opioid analgesics.

Sec. 2. Minnesota Statutes 2022, section 256B.0638, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Minnesota health care program" means a public health care program administered by the commissioner of human services under this chapter and chapter 256L, and the Minnesota restricted recipient program.

(f) "Opioid ~~disenrollment~~ sanction standards" means ~~parameters~~ clinical indicators defined by the Opioid Prescribing Work Group of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider ~~must~~

~~be disenrolled~~ may be subject to sanctions under section 256B.064 as a ~~medical assistance~~ Minnesota health care program provider.

(g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to ~~medical assistance~~ Minnesota health care program and MinnesotaCare enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(h) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(i) "Program" means the statewide opioid prescribing improvement program established under this section.

(j) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(k) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Sec. 3. Minnesota Statutes 2022, section 256B.0638, subdivision 4, is amended to read:

Subd. 4. **Program components.** (a) The working group shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, including, but not limited to, the following:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which for purposes of this program means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing opioid quality improvement standard thresholds and ~~opioid disenrollment~~ standards for opioid prescribers and provider groups~~. In developing opioid disenrollment standards, the standards may be described in terms of the length of time in which prescribing~~

~~practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards~~; and

(5) addressing other program issues as determined by the commissioners.

(b) The opioid prescribing protocols shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care or palliative care, or to opioids prescribed for substance use disorder treatment with medications for opioid use disorder.

(c) All opioid prescribers who prescribe opioids to Minnesota health care program enrollees must participate in the program in accordance with subdivision 5. Any other prescriber who prescribes opioids may comply with the components of this program described in paragraph (a) on a voluntary basis.

Sec. 4. Minnesota Statutes 2022, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the ~~programs within the Minnesota health care~~ quality improvement program to improve the health of and quality of care provided to Minnesota health care program enrollees. The program must be designed to support patient-centered care consistent with community standards of care. The program must discourage unsafe tapering practices and patient abandonment by providers. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) ~~appropriate use of the prescription monitoring program under section 152.126~~ demonstration of patient-centered care consistent with community standards of care.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices for treatment of acute or postacute pain do not improve so that they are consistent with community standards, the commissioner ~~shall~~ may take one or more of the following steps:

(1) require the prescriber, the provider group, or both, to monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts~~, including but not limited to mandatory use of the prescription monitoring program established under section 152.126~~.

(d) Prescribers treating patients who are on chronic, high doses of opioids must meet community standards of care, including performing regular assessments and addressing unwarranted risks of opioid prescribing, but are not required to show measurable changes in chronic pain prescribing thresholds within a certain period.

(e) The commissioner shall dismiss a prescriber from participating in the opioid prescribing quality improvement program when the prescriber demonstrates that the prescriber's practices are patient-centered and reflect community standards for safe and compassionate treatment of patients experiencing pain.

~~(d)~~ (f) The commissioner ~~shall terminate from Minnesota health care programs~~ may investigate for possible sanctions under section 256B.064 all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid ~~disenrollment~~ sanction standards.

(e) No physician, advanced practice registered nurse, or physician assistant, acting in good faith based on the needs of the patient, may be disenrolled by the commissioner of human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations specified in state or federal opioid prescribing guidelines or policies, or quality improvement thresholds established under this section.

Sec. 5. Minnesota Statutes 2022, section 256B.0638, is amended by adding a subdivision to read:

Subd. 8. **Sanction standards.** (a) Providers enrolled in medical assistance under section 256B.04, subdivision 21, providing services to persons enrolled in medical assistance or MinnesotaCare may be subject to sanctions under section 256B.064 for the following practices:

(1) discontinuing, either abruptly or in the form of a rapid taper, chronic opioid analgesic therapy from daily doses greater or equal to 50 morphine milligram equivalents a day without providing patient support. Discontinuing without providing patient support includes failing to:

(i) document and communicate to the patient a clinical rationale for the opioid discontinuation and for the taper plan or speed;

(ii) ascertain pregnancy status in women of childbearing age prior to beginning the discontinuation;

(iii) provide adequate follow-up care to the patient during the opioid discontinuation;

(iv) document a safety and pain management plan prior to or during the discontinuation;

(v) respond promptly and appropriately to patient-expressed psychological distress, including but not limited to suicidal ideation;

(vi) assess the patient for active, moderate to severe substance use disorder, including but not limited to opioid use disorder, and refer or treat the patient as appropriate; or

(vii) document and address patient harm when it arises. This includes but is not limited to known harms reported by the patient, harms evident in a clinical evaluation, or harms that should have been known through adequate chart review;

(2) continuing chronic opioid analgesic therapy without a safety plan when specific red flags for opioid use disorder are present. Failure to develop a safety plan includes but is not limited to failing to:

(i) document and address risks related to the condition or patterns of behavior and the potential health consequences that an undiagnosed or untreated opioid use disorder poses to the patient;

(ii) pursue a diagnosis when an opioid use disorder is suspected;

(iii) include a clear explanation of the safety plan in the patient's health record and evidence that the plan was communicated to the patient; and

(iv) document the clinical rationale for continuing therapy despite the presence of red flags. Red flags for opioid use disorder that require provider response under this section include:

(A) a history of overdose known to the prescriber or evident from the patient's medical record in the past 12 months;

(B) a history of an episode of opioid withdrawal that is not otherwise explained and is known to the prescriber or evident from the patient's medical record in the past 12 months;

(C) a known history of opioid use disorder. If the opioid use disorder is moderate to severe and the diagnosis was made within the past 12 months, a higher degree of consideration must be included in the safety plan;

(D) a history of opioid use resulting in neglect of other aspects of the patient's health that may result in serious harm known to the prescriber or evident from the patient's medical record in the past 12 months;

(E) an active alcohol use disorder. If the alcohol use disorder is moderate to severe, a higher degree of consideration must be included in the safety plan;

(F) a close personal contact of the patient expressing credible concern about the practice of use or safety of the patient indicating imminent harm to the patient or an opioid use disorder diagnosis;

(G) a pattern of deceptive actions by the patient to obtain opioid prescriptions. Deceptive actions may include but are not limited to forging prescriptions, tampering with prescriptions, and falsely reporting to medical staff with the intent of obtaining or protecting an opioid supply;

(H) a pattern of behavior by the patient that is indicative of loss of control or continued opioid use despite harm. Behaviors indicating a loss of control or continued use include but are not limited to a pattern of recurrent lost prescriptions, patient requests to increase dosage that are not supported by clinical reasoning, and a pattern of early refill requests without a change in clinical condition;

(3) prescribing greater than 400 morphine milligram equivalents per day without assessment of the risk for opioid-induced respiratory depression, without responding to evidence of opioid-related harm, and without mitigating the risk of opioid-induced respiratory depression. Failure to address risk of opioid-related harm includes but is not limited to failure to:

(i) assess and document the diagnosis or diagnoses to be managed with chronic opioid analgesic therapy;

(ii) assess and document comorbid health conditions that may impact the safety of opioid therapy;

(iii) screen and document a patient-specific, opioid-related risk benefit analysis;

(iv) respond to evidence of harm within the patient's medical record. Evidence of harm includes but is not limited to opioid-related falls, nonfatal overdoses, and appearing sedated or with respiratory compromise at clinical visits;

(v) document clinical decision making if dosage is increased;

(vi) document discussion of an opioid taper with the patient on at least an annual basis; and

(vii) evaluate the patient in person at least every three months or failing to assess for diversion;

(4) continuing chronic opioid analgesic therapy at the same dosage without a safety plan when risk factors for serious opioid-induced respiratory depression are present. Failing to develop a safety plan includes failing to document the risk factor as a risk of opioid-induced respiratory depression in the patient's health record and failing to document a clear safety plan in the patient's health record that addresses actions to reduce the risk for serious opioid-induced respiratory depression. Risk factors for serious opioid-induced respiratory depression include but are not limited to:

(i) an active or symptomatic and untreated substance use disorder;

(ii) a serious mental health condition, including symptomatic, untreated mania; symptomatic, untreated psychosis; and symptomatic, untreated suicidality;

(iii) an emergency department visit with a life-threatening opioid complication in the last 12 months;

(iv) a pattern of inconsistent urine toxicology results, excluding the presence of cannabinoids; however, addressing an inconsistent urine toxicology result must not result in the overall worsening clinical status of the patient;

(v) the concurrent prescribing of long-term benzodiazepine therapy to an individual on chronic opioid analgesic therapy;

(vi) a pulmonary disease with respiratory failure or hypoventilation; and

(vii) a failure to select and dose opioids safely for patients with known renal insufficiency; and

(5) failing to participate in the Opioid Prescribing Improvement program for two consecutive years.

Sec. 6. Minnesota Statutes 2022, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

(c) The commissioner may impose sanctions against a vendor for violations of the sanction standards defined by the Opioid Prescribing Work Group for opioid prescribing practices that fall outside community standard thresholds for prescribing.

EFFECTIVE DATE. This section is effective July 1, 2023.

ARTICLE 6
DEPARTMENT OF DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2022, section 15.01, is amended to read:

15.01 DEPARTMENTS OF THE STATE.

The following agencies are designated as the departments of the state government: the Department of Administration~~;~~, the Department of Agriculture~~;~~, the Department of

Commerce~~;~~, the Department of Corrections~~;~~, the Department of Direct Care and Treatment, the Department of Education~~;~~, the Department of Employment and Economic Development~~;~~, the Department of Health~~;~~, the Department of Human Rights~~;~~, the Department of Human Services, the Department of Information Technology Services~~;~~, the Department of Iron Range Resources and Rehabilitation~~;~~, the Department of Labor and Industry~~;~~, the Department of Management and Budget~~;~~, the Department of Military Affairs~~;~~, the Department of Natural Resources~~;~~, the Department of Public Safety~~; the Department of Human Services;~~, the Department of Revenue~~;~~, the Department of Transportation~~;~~, the Department of Veterans Affairs~~;~~, and their successor departments.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 2. Minnesota Statutes 2022, section 15.06, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** This section applies to the following departments or agencies: the Departments of Administration, Agriculture, Commerce, Corrections, Direct Care and Treatment, Education, Employment and Economic Development, Health, Human Rights, Human Services, Labor and Industry, Management and Budget, Natural Resources, Public Safety, ~~Human Services,~~ Revenue, Transportation, and Veterans Affairs; the Housing Finance and Pollution Control Agencies; the Office of Commissioner of Iron Range Resources and Rehabilitation; the Department of Information Technology Services; the Bureau of Mediation Services; and their successor departments and agencies. The heads of the foregoing departments or agencies are "commissioners."

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 3. Minnesota Statutes 2022, section 43A.08, subdivision 1a, is amended to read:

Subd. 1a. **Additional unclassified positions.** Appointing authorities for the following agencies may designate additional unclassified positions according to this subdivision: the Departments of Administration~~;~~, Agriculture~~;~~, Commerce~~;~~, Corrections~~;~~, Direct Care and Treatment, Education~~;~~, Employment and Economic Development~~;~~, Explore Minnesota Tourism~~;~~, Management and Budget~~;~~, Health~~;~~, Human Rights~~;~~, Human Services, Labor and Industry~~;~~, Natural Resources~~;~~, Public Safety~~;~~, ~~Human Services;~~ Revenue~~;~~, Transportation~~;~~, and Veterans Affairs; the Housing Finance and Pollution Control Agencies; the State Lottery; the State Board of Investment; the Office of Administrative Hearings; the Department of Information Technology Services; the Offices of the Attorney General, Secretary of State, and State Auditor; the Minnesota State Colleges and Universities; the Minnesota Office of

Higher Education; the Perpich Center for Arts Education; and the Minnesota Zoological Board.

A position designated by an appointing authority according to this subdivision must meet the following standards and criteria:

(1) the designation of the position would not be contrary to other law relating specifically to that agency;

(2) the person occupying the position would report directly to the agency head or deputy agency head and would be designated as part of the agency head's management team;

(3) the duties of the position would involve significant discretion and substantial involvement in the development, interpretation, and implementation of agency policy;

(4) the duties of the position would not require primarily personnel, accounting, or other technical expertise where continuity in the position would be important;

(5) there would be a need for the person occupying the position to be accountable to, loyal to, and compatible with, the governor and the agency head, the employing statutory board or commission, or the employing constitutional officer;

(6) the position would be at the level of division or bureau director or assistant to the agency head; and

(7) the commissioner has approved the designation as being consistent with the standards and criteria in this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 4. **[246C.01] TITLE.**

This chapter may be cited as the "Department of Direct Care & Treatment Act."

Sec. 5. **[246C.02] DEPARTMENT OF DIRECT CARE AND TREATMENT; ESTABLISHMENT.**

(a) The Department of Direct Care and Treatment is created. An executive board shall head the Department of Direct Care and Treatment. The executive board shall develop and maintain direct care and treatment in a manner consistent with applicable law, including chapters 13, 245, 246, 246B, 252, 253, 253B, 253C, 253D, 254A, 254B, and 256. The Department of Direct Care and Treatment shall provide direct care and treatment services in coordination with counties and other vendors. Direct care and treatment services shall include specialized inpatient programs at secure treatment facilities as defined in sections

253B.02, subdivision 18a, and 253D.02, subdivision 13; community preparation services; regional treatment centers; enterprise services; consultative services; aftercare services; community-based services and programs; transition services; nursing home services; and other services consistent with the mission of the Department of Direct Care and Treatment.

(b) "Community preparation services" means specialized inpatient or outpatient services or programs operated outside of a secure environment but administered by a secure treatment facility.

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 6. **[246C.03] TRANSITION OF AUTHORITY; DEVELOPMENT OF A BOARD.**

Subdivision 1. **Authority until board is developed and powers defined.** Upon the effective date of this act, the commissioner of human services shall continue to exercise all authorities and responsibilities under chapters 13, 245, 246, 246B, 252, 253, 253B, 253C, 253D, 254A, 254B, and 256, until legislation is effective that develops the Department of Direct Care and Treatment executive board and defines the responsibilities and powers of the Department of Direct Care and Treatment and its executive board.

Subd. 2. **Development of Department of Direct Care and Treatment Board.** (a) The commissioner of human services shall prepare legislation for introduction during the 2024 legislative session, with input from stakeholders the commissioner deems necessary, proposing legislation for the creation and implementation of the Direct Care and Treatment executive board and defining the responsibilities, powers, and function of the Department of Direct Care and Treatment executive board.

(b) The Department of Direct Care and Treatment executive board shall consist of no more than five members, all appointed by the governor.

(c) An executive board member's qualifications must be appropriate for overseeing a complex behavioral health system, such as experience serving on a hospital or non-profit board or working as a licensed health care provider, in an allied health profession, or in health care administration.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 7. **[246C.04] TRANSFER OF DUTIES.**

(a) Section 15.039 applies to the transfer of duties required by this chapter.

(b) The commissioner of administration, with the governor's approval, shall issue reorganization orders under section 16B.37 as necessary to carry out the transfer of duties required by section 246C.01. The provision of section 16B.37, subdivision 1, stating that transfers under section 16B.37 may only be to an agency that has existed for at least one year does not apply to transfers to an agency created by this chapter.

(c) The initial salary for the health systems chief executive officer of the Department of Direct Care and Treatment is the same as the salary for the health systems chief executive officer of direct care and treatment at the Department of Human Services immediately before July 1, 2024.

Sec. 8. **[246C.05] EMPLOYEE PROTECTIONS FOR ESTABLISHING THE NEW DEPARTMENT OF DIRECT CARE AND TREATMENT.**

(a) Personnel whose duties relate to the functions assigned to the commissioner of direct care and treatment in section 143.03 are transferred to the Department of Direct Care and Treatment effective 30 days after approval by the commissioner of direct care and treatment.

(b) Before the commissioner of direct care and treatment's appointment, personnel whose duties relate to the functions in this section may be transferred beginning July 1, 2024, with 30 days' notice from the commissioner of management and budget.

(c) The following protections shall apply to employees who are transferred from the Department of Human Services to the Department of Direct Care and Treatment:

(1) No transferred employee shall have their employment status and job classification altered as a result of the transfer.

(2) Transferred employees who were represented by an exclusive representative prior to the transfer shall continue to be represented by the same exclusive representative after the transfer.

(3) The applicable collective bargaining agreements with exclusive representatives shall continue in full force and effect for such transferred employees after the transfer.

(4) The state shall have the obligation to meet and negotiate with the exclusive representatives of the transferred employees about any proposed changes affecting or relating to the transferred employees' terms and conditions of employment to the extent such changes are not addressed in the applicable collective bargaining agreement.

(5) In the event that the state transfers ownership or control of any of the facilities, services, or operations of the Department of Direct Care and Treatment to another entity,

whether private or public, by subcontracting, sale, assignment, lease, or other transfer, the state shall require as a written condition of such transfer of ownership or control the following:

(i) Employees who perform work in transferred facilities, services, or operations must be offered employment with the entity acquiring ownership or control before the entity offers employment to any individual who was not employed by the transferring agency at the time of the transfer.

(ii) The wage and benefit standards of such transferred employees must not be reduced by the entity acquiring ownership or control through the expiration of the collective bargaining agreement in effect at the time of the transfer or for a period of two years after the transfer, whichever is longer.

(d) There is no liability on the part of, and no cause of action arises against, the state of Minnesota or its officers or agents for any action or inaction of any entity acquiring ownership or control of any facilities, services, or operations of the Department of Direct Care and Treatment.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 9. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with staff from the House Research Department; House Fiscal Analysis; the Office of Senate Counsel, Research and Fiscal Analysis; and the respective departments shall prepare legislation for introduction in the 2024 legislative session proposing the statutory changes necessary to implement the transfers of duties that this article requires.

EFFECTIVE DATE. This section is effective July 1, 2023.

ARTICLE 7
APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively.

"The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium" is fiscal years 2024 and 2025.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2024	2025

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	$	6,839,840,000	$ 7,232,523,000

Appropriations by Fund

	2024	2025
General	6,830,221,000	7,226,821,000
State Government Special Revenue	740,000	740,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	2,500,000	-0-

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Central Office; Operations**

Appropriations by Fund

	2024	2025
General	93,154,000	11,644,000
State Government Special Revenue	740,000	740,000

(a) **Staffing Costs.** Appropriations for staffing costs in this subdivision are available until June 30, 2027.

(b) **Base Level Adjustment.** The general fund base for this appropriation is $4,645,000 in fiscal year 2026 and $4,538,000 in fiscal year 2027.

Subd. 3. **Central Office; Children and Families**

	Appropriations by Fund		
General	1,214,000	3,999,000	

(a) **Staffing Costs.** Appropriations for staffing costs in this subdivision are available until June 30, 2027.

(b) **Base Level Adjustment.** The general fund base for this appropriation is $330,000 in fiscal year 2026 and $330,000 in fiscal year 2027.

Subd. 4. **Central Office; Health Care** 2,239,000 2,322,000

(a) **Staffing Costs.** Appropriations for staffing costs in this subdivision are available until June 30, 2027.

(b) **Base Level Adjustment.** The general fund base for this appropriation is $1,100,000 in fiscal year 2026 and $1,100,000 in fiscal year 2027.

(c) **Initial PACE Implementation Funding.** $270,000 in fiscal year 2024 is to complete the initial actuarial and administrative work necessary to recommend a financing mechanism for the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e). This is a onetime appropriation.

Subd. 5. **Central Office; Continuing Care for Older Adults** 14,120,000 21,666,000

(a) **Staffing Costs.** Appropriations for staffing costs in this subdivision are available until June 30, 2027.

(b) **Research on Access to Long-Term Care Services.** $700,000 in fiscal year 2024 is to support an actuarial research study of public and private financing options for long-term services and supports reform to increase access

across the state. This is a onetime appropriation.

(c) **Employment Supports Alignment Study.** $50,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are to conduct an interagency employment supports alignment study. The base for this appropriation is $150,000 in fiscal year 2026 and $100,000 in fiscal year 2027.

(d) **Case Management Training Curriculum.** $377,000 in fiscal year 2024 and $377,000 fiscal year 2025 are to develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for individuals who use home and community-based disability services and live in own-home settings. These are onetime appropriations.

(e) **Parent-to-Parent Programs.** (1) $625,000 in fiscal year 2024 and $625,000 in fiscal year 2025 are for grants to organizations supporting the organizations' parent-to-parent programs for families of children with special health care needs. This is a onetime appropriation and is available until June 30, 2025.

(2) Of this amount, $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for grants to organizations that provide services to underserved communities with a high prevalence of autism spectrum disorder. The commissioner shall give priority to organizations that provide culturally specific and culturally responsive services.

(3) Eligible organizations must:

(i) conduct outreach and provide support to newly identified parents or guardians of a child with special health care needs;

(ii) provide training to educate parents and guardians in ways to support their child and navigate the health, education, and human services systems;

(iii) facilitate ongoing peer support for parents and guardians from trained volunteer support parents; and

(iv) communicate regularly with other parent-to-parent programs and national organizations to ensure that best practices are implemented.

(4) Grant recipients must use grant money for the activities identified in clause (3).

(5) For purposes of this section, "special health care needs" means disabilities, chronic illnesses or conditions, health-related educational or behavioral problems, or the risk of developing disabilities, illnesses, conditions, or problems.

(6) Each grant recipient must report to the commissioner of human services annually by January 15 with measurable outcomes from programs and services funded by this appropriation the previous year including the number of families served and the number of volunteer support parents trained by the organization's parent-to-parent program.

(f) **Direct Care Service Corps Pilot Project.** $500,000 in fiscal year 2024 is for a grant to

HealthForce Minnesota at Winona State University for purposes of the direct care service corps pilot project. Up to $25,000 may be used by HealthForce Minnesota for administrative costs. This is a onetime appropriation.

(g) **Native American Elder Coordinator.** $441,000 in fiscal year 2024 and $441,000 in fiscal year 2025 are for the Native American elder coordinator position under Minnesota Statutes, section 256.975, subdivision 6. The base for this appropriation is $441,000 in fiscal year 2026 and $441,000 in fiscal year 2027.

(h) **Office of Ombudsman for Long-Term Care.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for additional staff and associated costs in the Office of Ombudsman for Long-Term Care.

(i) **Base Level Adjustment.** The general fund base for this appropriation is $6,476,000 in fiscal year 2026 and $6,378,000 in fiscal year 2027.

Subd. 6. **Central Office; Behavioral Health, Housing, and Deaf and Hard of Hearing Services** 8,690,000 10,138,000

(a) **Staffing Costs.** Appropriations for staffing costs in this subdivision are available until June 30, 2027.

(b) **Competency-based Training Funding for Substance Use Disorder Provider Community.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for provider participation in clinical training for the transition to American Society of Addiction

Medicine standards. This is a onetime appropriation.

(c) **Public Awareness Campaign.** $1,200,000 in fiscal year 2024 is to develop and establish a public awareness campaign targeting the stigma of opioid use disorders with the goal of prevention and education of youth on the dangers of opioids and other substance use pursuant to Minnesota Statutes, section 245.89. This is a onetime appropriation.

(d) **Bad Batch Overdose Surge Text Alert System.** $1,000,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are for development and ongoing funding for a text alert system notifying the public in real time of bad batch overdoses pursuant to Minnesota Statutes, section 245.891. This is a onetime appropriation.

(e) **Evaluation of Recovery Site Grants.** $300,000 in fiscal year 2025 is to provide funding for evaluating the effectiveness of recovery site grant efforts. This is a onetime appropriation.

(f) **Office of Addiction and Recovery.** $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for the Office of Addiction and Recovery.

(g) **Project ECHO.** $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for a grant to Hennepin Healthcare to expand the Project ECHO program. The grant must be used to establish at least four substance use disorder-focused Project ECHO programs at Hennepin Healthcare, expanding the grantee's

capacity to improve health and substance use disorder outcomes for diverse populations of individuals enrolled in medical assistance, including but not limited to immigrants, individuals who are homeless, individuals seeking maternal and perinatal care, and other underserved populations. The Project ECHO programs funded under this section must be culturally responsive, and the grantee must contract with culturally and linguistically appropriate substance use disorder service providers who have expertise in focus areas, based on the populations served. Grant funds may be used for program administration, equipment, provider reimbursement, and staffing hours. These are onetime appropriations.

(h) **Base Level Adjustment.** The general fund base is $3,467,000 in fiscal year 2026 and $3,367,000 in fiscal year 2027.

Subd. 7. **Forecasted Programs; Medical Assistance**	5,654,567,000	6,359,586,000
Subd. 8. **Forecasted Programs; Alternative Care**	47,793,000	51,035,000

Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 9. **Forecasted Programs; Behavioral Health Fund**	96,387,000	98,417,000
Subd. 10. **Grant Programs; Children and Economic Support Grants**	1,000,000	-0-

Minnesota Alliance for Volunteer Advancement. (1) $1,000,000 in fiscal year 2024 is for a grant to the Minnesota Alliance

for Volunteer Advancement to administer needs-based volunteerism subgrants that:

(i) target underresourced nonprofit organizations in greater Minnesota to support selected organizations' ongoing efforts to address and minimize disparities in access to human services through increased volunteerism; and

(ii) demonstrate that the populations to be served by the subgrantee are considered underserved or suffer from or are at risk of homelessness, hunger, poverty, lack of access to health care, or deficits in education.

(2) The Minnesota Alliance for Volunteer Advancement shall give priority to organizations that are serving the needs of vulnerable populations. By December 15, 2025, the Minnesota Alliance for Volunteer Advancement shall report data on outcomes from the subgrants and recommendations for improving and sustaining volunteer efforts statewide to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services. This is a onetime appropriation and is available until June 30, 2025.

Subd. 11. **Grant Programs; Refugee Services Grants** 3,000,000 18,000,000

New American Legal and Social Services Workforce Grant Program. $3,000,000 in fiscal year 2024 and $18,000,000 in fiscal year 2025 are for legal and social services grants. This is a onetime appropriation.

Subd. 12. **Grant Programs; Other Long-Term Care Grants** 44,772,000 25,925,000

(a) **Provider Capacity Grants for rural and Underserved Communities.** $24,000,000 in fiscal year 2025 is for grants under Minnesota Statutes, section 256.4761. This is a onetime appropriation.

(b) **Supporting New Americans in the Long-Term Care Workforce Grants.** $25,759,000 in fiscal year 2024 is for grants under Minnesota Statutes, section 256.4762.This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is $1,925,000 in fiscal year 2026 and $1,925,000 in fiscal year 2027.

Subd. 13. **Grant Programs; Aging and Adult Services Grants** 87,599,000 39,520,000

(a) **Age-Friendly Community Grants.** $0 in fiscal year 2024, $1,000,000 in fiscal year 2025, $1,000,000 in fiscal year 2026, and $1,000,000 in fiscal year 2027 are for the continuation of age-friendly community grants under Laws 2021, First Special Session chapter 7, article 17, section 8, subdivision 1. This is a onetime appropriation and is available until June 30, 2027.

(b) **Age-Friendly Technical Assistance Grants.** $0 in fiscal year 2024, $575,000 in fiscal year 2025, $575,000 in fiscal year 2026, and $575,000 in fiscal year 2027 are for the continuation of age-friendly technical assistance grants under Laws 2021, First Special Session chapter 7, article 17, section 8, subdivision 2. This is a onetime appropriation and is available until June 30, 2027.

(c) **Senior Nutrition Program.** $4,500,000 in fiscal year 2024 is for the senior nutrition program under Minnesota Statutes, section 256.9752. This is a onetime appropriation and is available until June 30, 2025.

(d) **Live Well at Home Grants.** $4,500,000 in fiscal year 2024 is for live well at home grants under Minnesota Statutes, section 256.9754. This is a onetime appropriation and is available until June 30, 2025.

(e) **Caregiver Respite Services Grants.** $1,800,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of human services for caregiver respite services grants under Minnesota Statutes, section 256.9756. This is a onetime appropriation.

(f) **Base Level Adjustment.** The general fund base is $32,995,000 in fiscal year 2026 and $32,995,000 in fiscal year 2027.

Subd. 14. **Grant Programs; Deaf and Hard of Hearing Grants**	2,886,000	2,886,000
Subd. 15. **Grant Programs; Disabilities Grants**	160,292,000	29,533,000

(a) **Transition Grants for Small Customized Living Providers.** $8,450,000 in fiscal year 2024 is for grants to assist transitions of small customized living providers as defined under Minnesota Statutes, section 245D.24. This is a onetime appropriation and is available through June 30, 2025.

(b) **Lead Agency Capacity Building Grants.** $500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025 are for grants to assist organizations, counties, and Tribes to build

capacity for employment opportunities for people with disabilities.

(c) **Employment and Technical Assistance Center Grants.** $450,000 in fiscal year 2024 and $1,800,000 in fiscal year 2025 are for employment and technical assistance grants to assist organizations and employers in promoting a more inclusive workplace for people with disabilities.

(d) **Case Management Training Grants.** $37,000 in fiscal year 2024, $123,000 in fiscal year 2025, $45,000 in fiscal year 2026, and $45,000 in fiscal year 2027 are for grants to provide case management training to organizations and employers to support the state's disability employment supports system.

(e) **Electronic Visit Verification Stipends.** $6,095,000 in fiscal year 2024 is for onetime stipends of $200 to bargaining members to offset the potential costs related to people using individual devices to access the electronic visit verification system. $5,600,000 of the appropriation is for stipends and the remaining amount is for administration of these stipends. This is a onetime appropriation and is available until June 30, 2025.

(f) **Self-Directed Collective Bargaining Agreement; Temporary Rate Increase Memorandum of Understanding.** $1,600,000 in fiscal year 2024 is for onetime stipends for individual providers covered by the SEIU collective bargaining agreement based on the memorandum of understanding related to the temporary rate increase in effect between December 1, 2020, and February 7, 2021.

$1,400,000 of the appropriation is for stipends and the remaining amount is for administration of the stipends. This is a onetime appropriation.

(g) **Self-Directed Collective Bargaining Agreement; Retention Bonuses.** $50,750,000 in fiscal year 2024 is for onetime retention bonuses covered by the SEIU collective bargaining agreement. $50,000,000 of the appropriation is for retention bonuses and the remaining amount is for administration of the bonuses. This is a onetime appropriation and is available until June 30, 2025.

(h) **Training Stipends.** $2,100,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are for onetime stipends of $500 for collective bargaining unit members who complete designated, voluntary trainings made available through or recommended by the State Provider Cooperation Committee. $2,000,000 of the appropriation is for stipends and the remaining amount in both fiscal year 2024 and fiscal 2025 is for the administration of stipends. This is a onetime appropriation.

(i) **Orientation Program.** $2,000,000 in fiscal year 2024 and$2,000,000 in fiscal year 2025 are for onetime $100 payments for collective bargaining unit members who complete voluntary orientation requirements. $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for the onetime payments, while $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for orientation related costs. This is a onetime appropriation.

(j) **HIV/AIDS Support Services.** $24,200,000 in fiscal year 2024 is for grants to community-based HIV/AIDS support services providers and for payment of allowed health care costs as defined in Minnesota Statutes, section 256.935. This is a onetime appropriation and is available through June 30, 2027.

(k) **Home Care Orientation Trust.** $1,000,000 in fiscal year 2024 is for the Home Care Orientation Trust in Article 10 of the 2023-2025 collective bargaining agreement between the state of Minnesota and Service Employees International Union Healthcare Minnesota and Iowa. The commissioner shall disburse the appropriation to the board of trustees of the Home Care Orientation Trust for deposit into an account designed by the board of trustees outside of the state treasury and state's accounting system. This is a onetime appropriation.

(l) **Home and Community-Based Workforce Incentive Fund Grants.** $33,300,000 in fiscal year 2024 is for home and community-based workforce incentive fund grants. This is a onetime appropriation. This is a onetime appropriation and is available until June 30, 2026.

(m) **Base Level Adjustment.** The general fund base is $27,355,000 in fiscal year 2026 and $27,030,000 in fiscal year 2027.

Subd. 16. **Grant Programs; Adult Mental Health Grants**	1,500,000	1,500,000

African American Child Wellness Institute. $3,000,000 in fiscal year 2024 is for a grant

to the African American Child Wellness Institute, a culturally specific African American mental health service provider that is a licensed community mental health center specializing in services for African American children and families of all ages. The grant must be used to support the center in offering culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder services; supervision and training; and care coordination regardless of ability to pay or place of residence. This is a onetime appropriation.

Subd. 17. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	88,288,000	4,997,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	-0-

(a) **Safe Recovery Sites.** $55,491,000 in fiscal year 2024 is for start-up and capacity-building grants for organizations to establish safe recovery sites. This appropriation is onetime and is available until June 30, 2025.

(b) **Culturally Specific Services Grants.** $4,000,000 in fiscal year 2024 is for grants to culturally specific providers for technical assistance navigating culturally specific and responsive substance use and recovery programs. This is a onetime appropriation.

(c) **Culturally Specific Grant Development Trainings.** $200,000 in fiscal year 2024 and

$200,000 in fiscal year 2025 are for up to four trainings for community members and culturally specific providers for grant writing training for substance use and recovery programs. This is onetime appropriation.

(d) **Harm Reduction Supplies for Tribal and Culturally Specific Programs.** $8,000,000 in fiscal year 2024 is to provide sole source grants to culturally specific communities to purchase syringes, testing supplies, and naloxone. This is a onetime appropriation.

(e) **Families and family Treatment Capacity-building and Start-up Grants.** $10,000,000 in fiscal year 2024 is for start-up and capacity-building grants for family substance use disorder treatment programs. Any unexpended funds are available until June 30, 2029. This is a onetime appropriation.

(f) **Minnesota State University, Mankato Community Behavioral Health Center.** $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025 are for a grant to the Center for Rural Behavioral Health at Minnesota State University, Mankato to establish a community behavioral health center and training clinic. The community behavioral health center must provide comprehensive, culturally specific, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder treatment services in Blue Earth County and the surrounding region. The center must provide the services to individuals of all ages, regardless of ability to pay or place of

residence. The community behavioral health center and training clinic must also provide training and workforce development opportunities to students enrolled in the university's training programs in the fields of social work, counseling and student personnel, alcohol and drug studies, psychology, and nursing. The commissioner shall make information regarding the use of this grant funding available to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. Any unspent money from the fiscal year 2024 appropriation is available in fiscal year 2025. These are onetime appropriations.

(g) **Wellness in the Woods.** $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are for a grant to Wellness in the Woods for daily peer support and special sessions for individuals who are in substance use disorder recovery, are transitioning out of incarceration, or who have experienced trauma. These are onetime appropriations.

(h) **Recovery Community Organization Grants.** $4,300,000 in fiscal year 2024 is for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, that are current grantees as of June 30, 2023. This is a onetime appropriation and is available until June 30, 2025.

(i) **Opioid Overdose Prevention Grants.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for a grant to Ka Joog, a

nonprofit organization in Minneapolis, Minnesota, to be used for collaborative outreach, education, and training on opioid use and overdose, and distribution of naloxone kits in East African and Somali communities in Minnesota. This is a onetime appropriation.

(j) **Problem Gambling.** $225,000 in fiscal year 2024 and $225,000 in fiscal year 2025 are from the lottery prize fund for a grant to a state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, training for individuals and organizations that provide effective treatment services to problem gamblers and their families, and research related to problem gambling.

(k) **Base Level Adjustment.** The general fund base is $3,247,000 in fiscal year 2026 and $3,247,000 in fiscal year 2027.

Subd. 18. **Direct Care and Treatment - Transfer Authority**

(a) Money appropriated for budget activities under subdivisions 17 to 21 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) Ending balances in obsolete accounts in the special revenue fund and other dedicated accounts within direct care and treatment may be transferred to other dedicated and gift fund accounts within direct care and treatment for client use and other client activities, with approval of the commissioner of management

and budget. These transactions shall be completed by June 30, 2023.

Subd. 19. **Direct Care and Treatment - Mental Health and Substance Abuse** 169,962,000 177,152,000

(a) The commissioner responsible for operations of direct care and treatment services, with the approval of the commissioner of management and budget, may transfer any balance in the enterprise fund established for the community addiction recovery enterprise program to the general fund appropriation within this subdivision. Any balance remaining after June 30, 2025, cancels to the general fund.

(b) During fiscal year 2024 and fiscal year 2025 balances in the chemical dependency services fund may be transferred to the general fund appropriation within this subdivision with the approval of the commissioner of management and budget. Balances remaining in the Department of Human Services chemical dependency services fund on July 1, 2026, shall cancel to the state's general fund.

Subd. 20. **Direct Care and Treatment - Community-Based Services** 20,386,000 21,164,,000

Base Level Adjustment. The general fund base is $20,452,000 in fiscal year 2026 and $20,452,000 in fiscal year 2027.

Subd. 21. **Direct Care and Treatment - Forensic Services** 141,020,000 148,513,000

Subd. 22. **Direct Care and Treatment - Sex Offender Program** 115,920,000 121,726,000

Subd. 23. **Direct Care and Treatment - Operations** 78,432,000 95,098,000

The general fund base is $65,263,000 in fiscal year 2026 and $65,263,000 in fiscal year 2027.

Sec. 3. **COUNCIL ON DISABILITY** $ 1,902,000 $ 2,282,000

Council on Disability; Accessibility Standards Training. (1) $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are for the Minnesota Council on Disability to select, appoint, and compensate employees to perform the following tasks:

(i) in consultation with the League of Minnesota Cities and the Association of Minnesota Counties, provide a statewide training module for cities and counties on how to conform local government websites to accessibility standards;

(ii) provide outreach, training, and technical assistance for local government officials and staff on website accessibility; and

(iii) track and compile information about the outcomes of the activities described in clauses (1) and (2) and the costs of implementation for cities and counties to make website accessibility improvements.

(2) The training module described under paragraph (a), clause (1), must be developed and made available to counties and cities on or before July 1, 2024.

(3) This is a onetime appropriation.

Sec. 4. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** $ 3,441,000 $ 3,644,000

Sec. 5. Laws 2021, First Special Session chapter 7, article 16, section 28, as amended by Laws 2022, chapter 40, section 1, is amended to read:

Sec. 28. **CONTINGENT APPROPRIATIONS.**

Any appropriation in this act for a purpose included in Minnesota's initial state spending plan as described in guidance issued by the Centers for Medicare and Medicaid Services for implementation of section 9817 of the federal American Rescue Plan Act of 2021 is contingent upon the initial approval of that purpose by the Centers for Medicare and Medicaid Services, except for the rate increases specified in article 11, sections 12 and 19. This section expires June 30, 2024.

Sec. 6. **DIRECT CARE AND TREATMENT FISCAL YEAR 2023 APPROPRIATION.**

$4,829,000 is appropriated in fiscal year 2023 to the commissioner of human services for operation of direct care and treatment programs. This is a onetime appropriation.

Sec. 7. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2025, within fiscal years among the MFIP; general assistance; medical assistance; MinnesotaCare; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid program; housing support program; the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N; and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioner considers necessary, with the advance approval of the commissioner of management and budget. The commissioners shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 8. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation or transfer in this article is enacted more than once during the 2023 regular session, the appropriation or transfer must be given effect once."

Amend the title accordingly