A bill for an act

relating to human services; modifying provisions relating to aging and older adult services, disability services, long-term services and supports reform, substance use disorder treatment, housing supports, health care, direct care and treatment services, and the Department of Health; establishing the Department of Direct Care and Treatment; making conforming changes; establishing grants; requiring reports; appropriating money; amending Minnesota Statutes 2024, sections 10.65, subdivision 2; 15.01; 15.06, subdivision 1; 15A.0815, subdivision 2; 15A.082, subdivisions 1, 3, 7; 43A.08, subdivisions 1, 1a; 43A.241; 144.0724, subdivisions 2, 11, by adding a subdivision; 144A.01, subdivision 4; 144A.071, subdivisions 4a, 4d; 144A.161, subdivision 10; 144A.1888; 144A.351, subdivision 1; 144A.474, subdivision 11; 144A.4799; 144G.08, subdivision 15; 144G.31, subdivision 8; 144G.52, subdivisions 1, 2, 3, 8; 144G.54, subdivisions 3, 7; 144G.55, subdivision 1; 179A.54, by adding a subdivision; 245.021; 245.073; 245A.042, by adding a subdivision; 245A.06, subdivisions 1a, 2; 245C.16, subdivision 1; 245D.091, subdivisions 2, 3; 245D.12; 245G.01, subdivision 13b, by adding subdivisions; 245G.02, subdivision 2; 245G.05, subdivision 1; 245G.07, subdivisions 1, 3, 4, by adding subdivisions; 245G.11, subdivision 6, by adding a subdivision; 245G.22, subdivisions 11, 15; 246.13, subdivision 1; 246B.01, by adding a subdivision; 246C.01; 246C.015, subdivision 3, by adding a subdivision; 246C.02, subdivision 1; 246C.04, subdivisions 2, 3; 246C.07, subdivisions 1, 2, 8; 246C.08; 246C.09, subdivision 3; 246C.091, subdivisions 2, 3, 4; 252.021, by adding a subdivision; 252.32, subdivision 3; 252.50, subdivision 5; 253.195, by adding a subdivision; 253B.02, subdivisions 3, 4c, by adding a subdivision; 253B.03, subdivision 7; 253B.041, subdivision 4; 253B.09, subdivision 3a; 253B.18, subdivision 6; 253B.19, subdivision 2; 253B.20, subdivision 2; 253D.02, subdivision 3, by adding a subdivision; 254B.01, subdivision 10; 254B.04, subdivision 1a; 254B.05, subdivisions 1, 4, 5, by adding a subdivision; 254B.06, by adding a subdivision; 254B.09, subdivision 2; 254B.19, subdivision 1; 256.01, subdivision 29, by adding subdivisions; 256.042, subdivision 4; 256.043, subdivisions 3, 3a; 256.045, subdivisions 6, 7, by adding a subdivision; 256.476, subdivision 4; 256.9657, subdivision 1; 256.9752, subdivisions 2, 3; 256B.04, subdivision 21; 256B.0625, subdivisions 5m, 17; 256B.0659, subdivision 17a; 256B.0757, subdivision 4c; 256B.0761, subdivision 4; 256B.0911, subdivisions 1, 10, 13, 14, 24, 26, by adding subdivisions; 256B.092, subdivision 1a; 256B.0924, subdivision 6; 256B.0949, subdivisions 2, 13, 15, 16, 16a, by adding a subdivision; 256B.431, subdivision 30; 256B.434, subdivision 4; 256B.49, subdivisions 12, 13, 18, by adding subdivisions; 256B.4914, subdivisions 3, 5, 5a, 5b, 6a, 6b, 6c, 7a, 7b, 7c, 8, 9, by

adding subdivisions; 256B.761; 256B.766; 256B.85, subdivisions 2, 5, 7, 7a, 8, 8a, 11, 13, 16, 17a, by adding a subdivision; 256B.851, subdivisions 5, 6, 7, by adding subdivisions; 256G.09, subdivision 3; 256I.05, by adding subdivisions; 256R.02, subdivisions 18, 19, 22, by adding subdivisions; 256R.10, subdivision 8; 256R.23, subdivisions 5, 7, 8; 256R.24, subdivision 3; 256R.25; 256R.26, subdivision 9; 256R.27, subdivisions 2, 3; 256R.43; 256S.205, subdivisions 2, 3, 5; 260E.14, subdivision 1; 352.91, subdivisions 2a, 3c, 3d, 4a; 524.3-801; 611.43, by adding a subdivision; 611.46, subdivision 1; 611.55, by adding a subdivision; 611.57, subdivision 2; 626.5572, subdivision 13; Laws 2021, chapter 30, article 12, section 5, as amended; Laws 2021, First Special Session chapter 7, article 13, sections 73; 75, subdivision 6, as amended; Laws 2023, chapter 61, article 1, section 61, subdivision 4; article 9, section 2, subdivisions 13, 16, as amended; Laws 2024, chapter 127, article 49, section 9, subdivisions 1, 8, 9, by adding a subdivision; article 50, section 41, subdivision 2; article 53, section 2, subdivisions 13, 15; proposing coding for new law in Minnesota Statutes, chapters 145D; 245A; 245D; 246; 246C; 256; 256R; repealing Minnesota Statutes 2024, sections 144A.071, subdivision 4c; 245A.042, subdivisions 2, 3, 4; 245G.01, subdivision 20d; 245G.07, subdivision 2; 246B.01, subdivision 2; 246C.015, subdivisions 5a, 6; 246C.06, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10; 246C.07, subdivisions 4, 5; 252.021, subdivision 2; 253.195, subdivision 2; 253B.02, subdivision 7b; 253D.02, subdivision 7a; 254B.01, subdivisions 5, 15; 254B.18; 256.045, subdivision 1a; 256B.0949, subdivision 9; 256G.02, subdivision 5a; 256R.02, subdivision 38; 256R.12, subdivision 10; 256R.23, subdivision 6; 256R.36; 256R.40; 256R.41; 256R.481; 256S.205, subdivision 7; Laws 2023, chapter 59, article 3, section 11; Laws 2024, chapter 79, article 1, section 20; Laws 2024, chapter 125, article 5, sections 40; 41; Laws 2024, chapter 127, article 46, section 39; article 50, sections 40; 41, subdivisions 1, 3.

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

ARTICLE 1

AGING AND OLDER ADULT SERVICES

Section 1. Minnesota Statutes 2024, section 144.0724, subdivision 2, is amended to read:

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

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the case mix reimbursement classifications determined by an assessment.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories

specified by the Centers for Medicare and Medicaid Services and designated by the Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Activities of daily living" or "ADL" includes personal hygiene, dressing, bathing, transferring, bed mobility, locomotion, eating, and toileting.

(g) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under chapter 256R;

(2) elderly waiver services under chapter 256S;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

(h) "Patient Driven Payment Model" or "PDPM" means the case mix reimbursement classification system for residents in nursing facilities according to the resident's condition, the resident's diagnosis, and the care the resident is receiving as reflected in data supplied in the facility's MDS with an ARD on or after October 1, 2025.

(i) "Resource utilization group" or "RUG" means the case mix reimbursement classification system for residents in nursing facilities according to the resident's clinical and functional status as reflected in data supplied by the facility's MDS with an ARD on or before September 30, 2025.

EFFECTIVE DATE. This section is effective October 1, 2025, and applies to assessments conducted on or after that date.

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase

beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

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

~~(g)~~ (f) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

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

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

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

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

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

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

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

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

~~(p)~~ (i) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as

voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee~~. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:~~;

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

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

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

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

~~(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the~~

~~same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;~~

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

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

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

~~(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed~~

~~rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;~~

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

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

~~(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256R.26. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256R.50;~~

~~(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by~~

~~the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;~~

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

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

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

~~(cc)~~ (k) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary; or

~~(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces~~

~~are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;~~

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

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

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

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

~~(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.~~

(l) to license or certify beds under provisions coded in this subdivision before the enactment of this law as paragraphs (f), (i) to (k), (m) to (bb), and (dd) to (ii).

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

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

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

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

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

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

(b) For purposes of calculating the net ~~cost~~ savings ~~to the state~~, the commissioner shall consider clauses (1) to ~~(7)~~ (6):

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

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

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

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

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

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

~~(7)~~ (6) the savings from not ~~paying external fixed costs payment rate adjustments~~ providing a rate adjustment from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

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

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

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

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

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

~~(f)~~ (d) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for

five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

~~(g) Projects approved on or after March 1, 2020, are not subject to paragraph (a), clauses (2) and (3), and paragraph (e). The 65~~ (e) Sixty-five percent of the projected net ~~cost~~ savings ~~to the state~~ calculated in paragraph (b) must be applied to the moratorium cost of the project and the remainder must be added to the moratorium funding under section 144A.073, subdivision 11.

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

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

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

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

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

Sec. 5. Minnesota Statutes 2024, section 144A.1888, is amended to read:

144A.1888 REUSE OF FACILITIES.

Notwithstanding any local ordinance related to development, planning, or zoning to the contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or changes operations shall be considered a conforming use permitted under local law, provided that the facility is converted to another long-term care service ~~approved by a regional~~

~~planning group under section 256R.40~~ that serves a smaller number of persons than the number of persons served before the closure or curtailment, reduction, or change in operations.

Sec. 6. Minnesota Statutes 2024, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as ~~$620~~ $2,815 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. ~~Beds on layaway status continue to be subject to the surcharge.~~ The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

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

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

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

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

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

Sec. 7. **[256.9746] AGE-FRIENDLY MINNESOTA COUNCIL.**

Subdivision 1. **Establishment.** The Age-Friendly Minnesota Council is established to coordinate work across sectors, including state government, nonprofits, communities, businesses, and others, to ensure the state is an age-friendly state.

Subd. 2. **Membership.** (a) The council consists of 15 voting members.

(b) Each of the following commissioners and multimember state agencies must designate an Age-Friendly Minnesota lead and appoint that designee to serve as a council member:

(1) the Minnesota Board on Aging;

(2) the commissioner of commerce;

(3) the commissioner of employment and economic development;

(4) the commissioner of health;

(5) the commissioner of housing;

(6) the commissioner of human services;

(7) the commissioner of transportation;

(8) the commissioner of veterans affairs; and

(9) the Metropolitan Council.

(c) The governor shall appoint six additional public members to represent older adults in communities experiencing disparities, direct service caregivers, businesses, experts on aging, local governments, and Tribal communities. The appointment, terms, compensation, and removal of public members shall be as provided in section 15.059.

(d) Other state agencies and boards may participate on the council in a nonvoting capacity.

Subd. 3. **Chairperson; executive committee.** (a) The council shall elect a chairperson and other officers as it deems necessary and in accordance with the council's operating procedures.

(b) The council shall be governed by an executive committee elected by the members of the council. One member of the executive committee must be the council chairperson.

(c) The executive committee may appoint additional subcommittees and work groups as necessary to fulfill the duties of the council.

Subd. 4. **Meetings.** (a) The council shall meet at the call of the chairperson or at the request of a majority of council members. The council must meet at least quarterly. Meetings of the council are subject to section 13D.01, and notice of its meetings is governed by section 13D.04.

(b) Notwithstanding section 13D.01, the council may conduct a meeting of its members by telephone or other electronic means so long as:

(1) all members of the council participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the council can hear all discussion and all votes of members of the council and participate in testimony;

(3) at least one member of the council is physically present at the regular meeting location; and

(4) each member's vote on each issue is identified and recorded by a roll call.

(c) Each member of the council participating in a meeting by telephone or other electronic means is considered present at the meeting for the purposes of determining a quorum and participating in all proceedings. If telephone or another electronic means is used to conduct a meeting, the council, to the extent practicable, shall allow a person to monitor the meeting from a remote location. If telephone or another electronic means is used to conduct a regular, special, or emergency meeting, the council shall provide notice of the regular meeting location, that some members may participate by electronic means, and of the option to monitor the meeting electronically from a remote location.

Subd. 5. **Duties.** (a) The council's duties may include but are not limited to:

(1) elevating the voice of older adults in developing the vision and action plan for an age-friendly state;

(2) engaging with the community, including older adults, caregivers, businesses, experts, advocacy organizations, and other interested parties, to provide recommendations and update interested parties on the council's recommendations;

(3) identifying opportunities for and barriers to collaboration and coordination among services and state agencies responsible for funding and administering programs and public-private partnerships;

(4) promoting equity and making progress toward equitable outcomes by examining programs, policies, and practices to ensure they address disparities experienced by older adults in greater Minnesota, older adults of color, and indigenous older adults;

(5) catalyzing age-friendly work at the local level, engaging with and empowering older adults, local constituents, elected officials, and other interested parties to create change in every community;

(6) establishing a statewide framework that allows for local flexibility to tap into the potential presented by our aging communities and elevates aging across all of Minnesota;

(7) reviewing, awarding, and monitoring grants under section 256.9747;

(8) assessing and examining relevant programs, policies, practices, and services to make budget and policy recommendations to establish age-friendly policies in law with appropriate financial support to ensure Minnesota continues to lead on age-friendly initiatives; and

(9) making budget and policy recommendations to the governor, commissioners, boards, other state agencies, and the legislature to further the council's mission to ensure the state is an age-friendly state.

(b) The council may accept technical assistance and in-kind services from outside organizations for purposes consistent with the council's role and authority.

Subd. 6. **Administration.** The Minnesota Board on Aging and Department of Human Services shall provide staffing and administrative support to the council.

Subd. 7. **Annual report.** Beginning January 1, 2026, and every two years thereafter, the council shall publish a public report on the council's activities, the uses and measurable outcomes of the grant activities funded under section 256.9747, the council's recommendations, proposed changes to statutes or rules, and other issues the council may choose to report.

Sec. 8. **[256.9747] AGE-FRIENDLY MINNESOTA GRANTS.**

Subdivision 1. **Age-friendly community grants.** The commissioner of human services, in collaboration with the Minnesota Board on Aging and the Age-Friendly Minnesota Council, shall develop the age-friendly community grant program to help communities, including cities, counties, other municipalities, Tribes, and collaborative efforts become age-friendly communities, with an emphasis on structures, services, and community features necessary to support older adult residents, 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.

Subd. 2. **Age-friendly technical assistance grants.** The commissioner of human services, in collaboration with the Minnesota Board on Aging and the Age-Friendly Minnesota Council, shall develop the age-friendly technical assistance grant program to support communities and organizations who need assistance in applying for age-friendly community grants and implementing various aspects of their grant-funded projects.

Sec. 9. Minnesota Statutes 2024, section 256.9752, subdivision 2, is amended to read:

Subd. 2. **Authority.** The Minnesota Board on Aging shall allocate to area agencies on aging the ~~state and~~ federal funds which are received for the senior nutrition programs of congregate dining and home-delivered meals in a manner consistent with federal requirements.

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

Sec. 10. Minnesota Statutes 2024, section 256.9752, subdivision 3, is amended to read:

Subd. 3. **Nutrition support services.** (a) Funds allocated to an area agency on aging for nutrition support services may be used for the following:

(1) transportation of home-delivered meals and purchased food and medications to the residence of a senior citizen;

(2) expansion of home-delivered meals into unserved and underserved areas;

(3) transportation to supermarkets or delivery of groceries from supermarkets to homes;

(4) vouchers for food purchases at selected restaurants in isolated rural areas;

(5) the Supplemental Nutrition Assistance Program (SNAP) outreach;

(6) transportation of seniors to congregate dining sites;

(7) nutrition screening assessments and counseling as needed by individuals with special dietary needs, performed by a licensed dietitian or nutritionist; ~~and~~

(8) other appropriate services which support senior nutrition programs, including new service delivery models; and

(9) innovative models of providing healthy and nutritious meals to seniors, including through partnerships with schools, restaurants, and other community partners.

(b) An area agency on aging may transfer unused funding for nutrition support services to fund congregate dining services and home-delivered meals, but state funds transferred under this paragraph are not subject to federal requirements.

Sec. 11. Minnesota Statutes 2024, section 256B.431, subdivision 30, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

these purposes to the total square footage made available as a result of bed layaway or delicensure.

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

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

Sec. 12. Minnesota Statutes 2024, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning on and after January 1, ~~2019~~ 2026, a nursing facility's property payment rate ~~for the second and subsequent years of a facility's contract~~ under this section ~~are~~ is the facility's previous rate year's property payment rate ~~plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the Reports and Forecasts Division of the Department of Human Services, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined~~.

Sec. 13. Minnesota Statutes 2024, section 256R.02, subdivision 18, is amended to read:

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

(1) premium expenses for group coverage;

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

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

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

Sec. 14. Minnesota Statutes 2024, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means ~~costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;~~

~~family advisory council fee under section 144A.33; scholarships under section 256R.37; planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41; property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; Public Employees Retirement Association employer costs; and border city rate adjustments under section 256R.481~~ the items described in section 256R.25.

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

Sec. 15. Minnesota Statutes 2024, section 256R.02, subdivision 22, is amended to read:

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

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

Sec. 16. Minnesota Statutes 2024, section 256R.02, is amended by adding a subdivision to read:

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

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

Sec. 17. Minnesota Statutes 2024, section 256R.02, is amended by adding a subdivision to read:

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

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

Sec. 18. Minnesota Statutes 2024, section 256R.10, subdivision 8, is amended to read:

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

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

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

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

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

Sec. 19. Minnesota Statutes 2024, section 256R.23, subdivision 5, is amended to read:

Subd. 5. **Determination of total care-related payment rate limits.** (a) The commissioner must determine each facility's total care-related payment rate limit by:

(1) multiplying the facility's quality score, as determined under section 256R.16, subdivision 1, by 0.5625;

(2) adding 89.375 to the amount determined in clause (1), and dividing the total by 100; and

(3) multiplying the amount determined in clause (2) by the median total care-related cost per day.

(b) Notwithstanding paragraph (a), effective January 1, 2026, through December 31, 2029, the commissioner must determine each facility's total care-related payment rate limit by:

(1) multiplying the facility's quality score, as determined under section 256R.16, subdivision 1, by 2.0;

(2) subtracting 40 from the amount determined in clause (1), and dividing the total by 100; and

(3) multiplying the amount determined in clause (2) by the median total care-related cost per day.

This paragraph expires January 1, 2030.

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

Sec. 20. Minnesota Statutes 2024, section 256R.23, subdivision 7, is amended to read:

Subd. 7. **Determination of direct care payment rates.** (a) A facility's direct care payment rate equals the lesser of (1) the facility's direct care costs per standardized day, or (2) the facility's direct care costs per standardized day divided by its cost to limit ratio.

(b) Notwithstanding paragraph (a), effective January 1, 2026, through December 31, 2029, a facility's direct care payment rate equals the lesser of (1) the facility's direct care costs per standardized day, (2) the facility's direct care costs per standardized day divided by its cost to limit ratio, or (3) 104 percent of the previous year's direct care payment rate. This paragraph expires January 1, 2030.

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

Sec. 21. Minnesota Statutes 2024, section 256R.23, subdivision 8, is amended to read:

Subd. 8. **Determination of other care-related payment rates.** (a) A facility's other care-related payment rate equals the lesser of (1) the facility's other care-related cost per

resident day, or (2) the facility's other care-related cost per resident day divided by its cost to limit ratio.

(b) Notwithstanding paragraph (a), effective January 1, 2026, through December 31, 2029, a facility's other care-related payment rate equals the lesser of (1) the facility's other care-related cost per resident day, (2) the facility's other care-related cost per resident day divided by its cost to limit ratio, or (3) 104 percent of the previous year's other care-related payment rate. This paragraph expires January 1, 2030.

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

Sec. 22. Minnesota Statutes 2024, section 256R.24, subdivision 3, is amended to read:

Subd. 3. **Determination of the other operating payment rate.** (a) A facility's other operating payment rate equals 105 percent of the median other operating cost per day.

(b) Notwithstanding paragraph (a), effective January 1, 2026, through December 31, 2029, a facility's other operating payment rate equals the lesser of 105 percent of the median other operating cost per day or 104 percent of the previous year's other operating payment rate. This paragraph expires January 1, 2030.

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

Sec. 23. Minnesota Statutes 2024, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

Subdivision 1. **Determination of external fixed cost payment rate.** ~~(a)~~ The payment rate for external fixed costs is the sum of the amounts in ~~paragraphs (b) to (p)~~ subdivisions 2 to 14.

Subd. 2. **Provider surcharges.** ~~(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.

Subd. 3. **Licensure fees.** ~~(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.

Subd. 4. **Advisory councils.** ~~(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.

Subd. 5. **Scholarships.** ~~(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.~~

Subd. 6. **Consolidation.** ~~(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~~ is the amount specified in section 256R.405.

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

Subd. 7. **Taxes.** ~~(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.

Subd. 8. **Health insurance.** ~~(j)~~ The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

Subd. 9. **Public employees retirement.** ~~(k)~~ The portion related to the Public Employees Retirement Association is the allowable costs divided by the sum of the facility's resident days.

Subd. 10. **Quality improvement incentives.** ~~(l)~~ The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

Subd. 11. **Performance-based incentives.** ~~(m)~~ The portion related to performance-based incentive payments is the amount determined under section 256R.38.

Subd. 12. **Special diets.** ~~(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.~~

Subd. 13. **Critical access facilities.** ~~(p)~~ The portion related to the rate adjustment for critical access nursing facilities is the amount determined under section 256R.47.

Subd. 14. **Workforce standards.** The portion related to implementation of the rules implemented by the Nursing Home Workforce Standards Board is the amount determined under section 256R.532.

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

Sec. 24. Minnesota Statutes 2024, section 256R.26, subdivision 9, is amended to read:

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

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

(c) Upon a facility's transition to the fair rental value property rates calculated under this chapter, the facility's total property payment rate under subdivision 8 shall be the only payment for costs related to capital assets, including depreciation, interest and lease expenses for all depreciable assets, including movable equipment, land improvements, and land. Facilities with property payment rates established under subdivisions 1 to 8 are not eligible for planned closure rate adjustments under Minnesota Statutes 2024, section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses ~~(5)~~ (1) and ~~(6)~~ (2), and 4d; single-bed room incentives under Minnesota Statutes 2024, section 256R.41; and the property rate inflation adjustment under Minnesota Statutes 2024, section 256B.434, subdivision 4. The commissioner shall remove any of these

incentives from the facility's existing rate upon the facility transitioning to the fair rental value property rates calculated under this chapter.

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

Sec. 25. Minnesota Statutes 2024, section 256R.27, subdivision 2, is amended to read:

Subd. 2. **Determination of interim payment rates.** (a) The nursing facility shall submit an interim cost report in a format similar to the Minnesota Statistical and Cost Report and other supporting information as required by this chapter for the reporting year in which the nursing facility plans to begin operation at least 60 days before the first day a resident is admitted to the newly constructed nursing facility bed. The interim cost report must include the nursing facility's anticipated interim costs and anticipated interim resident days for each resident class in the interim cost report. The anticipated interim resident days for each resident class is multiplied by the weight for that resident class to determine the anticipated interim standardized days as defined in section 256R.02, subdivision 50, and resident days as defined in section 256R.02, subdivision 45, for the reporting period.

(b) The interim payment rates are determined according to sections 256R.21 to 256R.25, except that:

(1) the anticipated interim costs and anticipated interim resident days reported on the interim cost report and the anticipated interim standardized days as defined by section 256R.02, subdivision 50, must be used for the interim;

(2) the commissioner shall use anticipated interim costs and anticipated interim standardized days in determining the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use anticipated interim costs and anticipated interim resident days in determining the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use anticipated interim costs and anticipated interim resident days to determine the allowable historical external fixed costs per day under section 256R.25, ~~paragraphs (b) to (k)~~ subdivisions 2 to 9;

(5) the total care-related payment rate limits established in section 256R.23, subdivision 5, and in effect at the beginning of the interim period must be increased by ten percent; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

Sec. 26. Minnesota Statutes 2024, section 256R.27, subdivision 3, is amended to read:

Subd. 3. **Determination of settle-up payment rates.** (a) When the interim payment rates begin between May 1 and September 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rates through September 30 of the following year.

(b) When the interim payment rates begin between October 1 and April 30, the nursing facility shall file settle-up cost reports for the period from the beginning of the interim payment rates to the first September 30 following the beginning of the interim payment rates.

(c) The settle-up payment rates are determined according to sections 256R.21 to 256R.25, except that:

(1) the allowable costs and resident days reported on the settle-up cost report and the standardized days as defined by section 256R.02, subdivision 50, must be used for the interim and settle-up period;

(2) the commissioner shall use the allowable costs and standardized days in clause (1) to determine the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use the allowable costs and the allowable resident days to determine both the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use the allowable costs and the allowable resident days to determine the allowable historical external fixed costs per day under section 256R.25, ~~paragraphs (b) to (k)~~ subdivisions 2 to 9;

(5) the total care-related payment limits established in section 256R.23, subdivision 5, are the limits for the settle-up reporting periods. If the interim period includes more than one July 1 date, the commissioner shall use the total care-related payment rate limit established in section 256R.23, subdivision 5, increased by ten percent for the second July 1 date; and

(6) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

Sec. 27. **[256R.405] CONSOLIDATION RATES.**

Subdivision 1. **Consolidation rates; generally.** The external fixed costs payment rate for nursing facilities that have completed a state-approved consolidation project must include a consolidation rate adjustment. A facility's consolidation rate adjustment expires upon transition to a fair rental value property payment rate under section 256R.26, subdivision 9. The commissioner must inform the revisor of statutes when a facility's consolidation rate adjustment specified under this section expires. This subdivision expires upon the expiration of all other subdivisions of this section.

Subd. 2. **Owatonna.** The consolidation rate for the nursing facility located at 2255 30th Street Northwest in Owatonna is $33.88.

Subd. 3. **Red Wing.** The consolidation rate for the nursing facility located at 213 Pioneer Road in Red Wing is $73.69.

Subd. 4. **White Bear Lake.** The consolidation rate for the nursing facility located at 1891 Florence Street in White Bear Lake is $25.56.

Subd. 5. **St. Paul.** The consolidation rate for the nursing facility located at 200 Earl Street in St. Paul is $68.01.

Subd. 6. **Cambridge.** The consolidation rate for the nursing facility located at 135 Fern Street North in Cambridge is $24.30.

Subd. 7. **Maple Plain.** The consolidation rate for the nursing facility located at 4848 Gateway Boulevard in Maple Plain is $38.76.

Subd. 8. **Maplewood.** The consolidation rate for the nursing facility located at 1438 County Road C East in Maplewood is $55.63.

Subd. 9. **Apple Valley.** The consolidation rate for the nursing facility located at 14650 Garrett Avenue in Apple Valley is $26.99.

Sec. 28. Minnesota Statutes 2024, section 256R.43, is amended to read:

256R.43 BED HOLDS.

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

based on the number of licensed and certified beds in the facility that are not in layaway status.

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

Sec. 29. **[256R.531] PATIENT DRIVEN PAYMENT MODEL PHASE-IN.**

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

Subd. 1a. **Definition.** "Medical assistance facility average case mix index" means the facility average case mix index for the subset of a facility's residents that includes only medical assistance recipients.

Subd. 2. **PDPM phase-in rate adjustment.** A facility's PDPM phase-in rate adjustment to its total payment rate is equal to:

(1) the blended medical assistance case mix adjusted direct care payment rate determined in subdivision 6; minus

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

Subd. 3. **RUG-IV standardized days and RUG-IV facility case mix index.** (a) Effective October 1, 2025, through December 31, 2027, for each facility, the commissioner must determine the RUG-IV standardized days and RUG-IV medical assistance facility average case mix index.

(b) For the rate year beginning January 1, 2028, only:

(1) for each facility, the commissioner must determine both the RUG-IV facility average case mix index and the RUG-IV medical assistance facility average case mix index using resident days by the case mix classification on the facility's September 30, 2025, Minnesota Statistical and Cost Report; and

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

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

(1) the facility's RUG-IV direct care payment rate determined in section 256R.23, subdivision 7, using the RUG-IV standardized days determined in subdivision 3; and

(2) the corresponding RUG-IV medical assistance facility average case mix index determined in subdivision 3.

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

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

(2) the corresponding medical assistance facility average case mix index.

Subd. 6. **Blended medical assistance case mix adjusted direct care payment rate.** The commissioner must determine a facility's blended medical assistance case mix adjusted direct care payment rate as the sum of:

(1) the RUG-IV medical assistance case mix adjusted direct care payment rate determined in subdivision 4 multiplied by the following percentages:

(i) after September 30, 2025, through December 31, 2026, 75 percent;

(ii) after December 31, 2026, through December 31, 2027, 50 percent; and

(iii) after December 31, 2027, through December 31, 2028, 25 percent; and

(2) the PDPM medical assistance case mix adjusted direct care payment rate determined in subdivision 5 multiplied by the following percentages:

(i) after September 30, 2025, through December 31, 2026, 25 percent;

(ii) after December 31, 2026, through December 31, 2027, 50 percent; and

(iii) after December 31, 2027, through December 31, 2028, 75 percent.

Subd. 7. **Expiration.** This section expires January 1, 2029.

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

Sec. 30. **[256R.532] NURSING FACILITY RATE ADD-ON FOR WORKFORCE STANDARDS.**

(a) Effective for rate years beginning on and after January 1, 2028, or upon federal approval, whichever is later, the commissioner shall annually provide a rate add-on amount for nursing facilities reimbursed under this chapter for the initial standards for wages for nursing home workers adopted by the Nursing Home Workforce Standards Board in Minnesota Rules, parts 5200.2060 to 5200.2090, pursuant to section 181.213, subdivision 2, paragraph (c). The add-on amount is equal to:

(1) $3.93 per resident day, effective January 1, 2028, through December 31, 2028; and

(2) $8.55 per resident day, effective January 1, 2029.

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

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

Sec. 31. Minnesota Statutes 2024, section 256S.205, subdivision 2, is amended to read:

Subd. 2. **Rate adjustment application.** (a) Effective through September 30, 2023, a facility may apply to the commissioner for an initial designation as a disproportionate share facility. Applications must be submitted annually between September 1 and September 30. The applying facility must apply in a manner determined by the commissioner. The applying facility must document each of the following on the application:

(1) the number of customized living residents in the facility on September 1 of the application year, broken out by specific waiver program; and

(2) the total number of people residing in the facility on September 1 of the application year.

(b) Effective October 1, 2023, the commissioner must not process any new initial applications for disproportionate share facilities ~~after the September 1 through September 30, 2023, application period~~.

(c) A facility that ~~receives~~ received rate floor payments in rate year 2024 may submit an annual application under this subdivision to maintain its designation as a disproportionate share facility ~~for rate year 2025~~.

Sec. 32. Minnesota Statutes 2024, section 256S.205, subdivision 3, is amended to read:

Subd. 3. **Rate adjustment eligibility criteria.** (a) ~~Effective through September 30, 2023,~~ Only facilities satisfying all of the following conditions on September 1 of the application year are eligible for designation as a disproportionate share facility:

(1) at least 83.5 percent of the residents of the facility are customized living residents; and

(2) at least 70 percent of the customized living residents are elderly waiver participants.

(b) A facility determined eligible for the disproportionate share rate adjustment in application year 2023 and receiving payments in rate year 2024 is eligible to receive payments in rate ~~year 2025~~ years beginning on or after January 1, 2025, only if the commissioner determines that the facility continues to meet the eligibility requirements under this subdivision as determined by the application process under subdivision 2, paragraph (c).

Sec. 33. Minnesota Statutes 2024, section 256S.205, subdivision 5, is amended to read:

Subd. 5. **Rate adjustment; rate floor.** (a) ~~Effective through December 31, 2025,~~ Notwithstanding the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2, and the component service rates established under section 256S.201, subdivision 4, the commissioner must establish a rate floor equal to $141 per resident per day for 24-hour customized living services provided to an elderly waiver participant in a designated disproportionate share facility.

(b) The commissioner must apply the rate floor to the services described in paragraph (a) provided during the rate year.

Sec. 34. Laws 2021, chapter 30, article 12, section 5, as amended by Laws 2021, First Special Session chapter 7, article 17, section 2, and Laws 2023, chapter 61, article 2, section 35, 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, ~~2027~~ 2025.

Sec. 35. **AGE-FRIENDLY MINNESOTA COUNCIL; CONTINUATION OF APPOINTMENTS AND DESIGNATION OF INITIAL TERMS.**

Subdivision 1. **Continuation of appointments.** Each member of the Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, serving on June 30, 2025, shall be deemed appointed to the Age-Friendly Minnesota Council by the applicable appointing authority under Minnesota Statutes, section 256.9746, effective July 1, 2025.

Subd. 2. **First meeting.** The individual who was serving as chairperson of the Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, as of June 30, 2025, must convene the first meeting of the Age-Friendly Minnesota Council no later than July 9, 2025. The former chairperson of the Governor's Council on an Age-Friendly Minnesota shall preside over the first meeting until the Age-Friendly Minnesota Council elects a chairperson.

Subd. 3. **Designation of initial terms.** The governor must notify the secretary of state which initial public members of the Age-Friendly Minnesota Council will have terms coterminous with that of the governor or request that the secretary of state randomly determine which initial public members will have terms coterminous with the governor's term.

Sec. 36. **DIRECTION TO THE COMMISSIONER; IMPACT STUDY OF REPEAL OF DISPROPORTIONATE SHARE PAYMENTS.**

(a) The commissioner of human services must conduct a study of the impact of the repeal of Minnesota Statutes, section 256S.205, on those facilities that received a rate floor payment in rate year 2025. For each facility that received a rate floor payment in rate year 2025, the commissioner must determine:

(1) how many facilities remain operational on September 1, 2026;

(2) the total number of residents of the facility on September 1, 2026;

(3) the proportion of residents of the facility who are customized living residents on September 1, 2026;

(4) the proportion of residents who are elderly waiver participants on September 1, 2026; and

(5) the difference by facility between the results under clauses (1) to (4) and the same or similar information submitted by the facility on its rate year 2025 application.

(b) The commissioner must solicit from each provider a summary of its financial position as of September 1, 2026, as compared to its financial position on September 1, 2025, and a statement of the facility's change in operational margin between September 1, 2025, and September 1, 2026. The controlling individual of a facility that submits a financial summary and statement of the facility's change in operational margin must attest to the accuracy of the financial summary and statement.

(c) By January 1, 2027, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services a report summarizing the data on the impact of the repeal of Minnesota Statutes, section 256S.205, on those facilities that received a rate floor payment in rate year 2025.

(d) The definitions in Minnesota Statutes 2024, section 256S.205, apply to this section.

Sec. 37. **REPEALER.**

(a) Minnesota Statutes 2024, sections 144A.071, subdivision 4c; 256R.02, subdivision 38; 256R.40; 256R.41; and 256R.481, are repealed.

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

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

(d) Minnesota Statutes 2024, section 256S.205, subdivision 7, is repealed.

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

ARTICLE 2
DISABILITY SERVICES

Section 1. Minnesota Statutes 2024, section 144.0724, subdivision 2, is amended to read:

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

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the case mix reimbursement classifications determined by an assessment.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Activities of daily living" includes personal hygiene, dressing, bathing, transferring, bed mobility, locomotion, eating, and toileting.

(g) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under chapter 256R;

(2) elderly waiver services under chapter 256S; and

~~(3) CADI and BI waiver services under section 256B.49; and~~

~~(4)~~ (3) state payment of alternative care services under section 256B.0913.

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. 2. Minnesota Statutes 2024, section 144.0724, subdivision 11, is amended to read:

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services specified in subdivision 2, paragraph (g), a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone or be homeless without the person's current housing and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraphs (b) and (c), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

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

Sec. 3. Minnesota Statutes 2024, section 144.0724, is amended by adding a subdivision to read:

Subd. 11a. **Determination of nursing facility level of care for the brain injury and community access for disability inclusion waivers.** (a) Effective January 1, 2026, or upon federal approval, whichever is later, a person must be determined to meet one of the following nursing facility level of care criteria to be eligible for the brain injury and community access for disability inclusion waivers under section 256B.49:

(1) the person requires the assistance of another person or constant supervision to begin and complete at least four of the following activities of daily living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, or walking;

(2) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled; or

(3) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require the person to be constantly supervised or require interventions that cannot be scheduled.

(b) Nursing facility level of care determinations for purposes of initial and ongoing access to the brain injury and community access for disability inclusion waiver programs must be conducted by a certified assessor under section 256B.0911.

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

Sec. 4. Minnesota Statutes 2024, section 144A.351, subdivision 1, is amended to read:

Subdivision 1. **Report requirements.** (a) The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall compile data regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. The compiled data shall include:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services and related mental health services, housing options, and supports by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and

(iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and changes over time; ~~and~~

(4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs~~.~~; and

(5) the following information on the availability of integrated community supports, updated within 30 days of the end of each of four three-month reporting periods, which begin on January 1 of each year:

(i) the average number of integrated community supports beds occupied, per month, for the preceding reporting period;

(ii) the average number of integrated community supports beds available, per month, for the preceding reporting period;

(iii) the number of integrated community supports setting applications being reviewed by the commissioner of human services as of the final day of the reporting period; and

(vi) the average time of review for integrated community supports setting applications submitted during the preceding quarter.

(b) The commissioners of health and human services shall make the compiled data available on at least one of the department's websites.

Sec. 5. Minnesota Statutes 2024, section 179A.54, is amended by adding a subdivision to read:

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

(b) The state must make financial contributions to the Minnesota Caregiver Retirement Fund Trust pursuant to a collective bargaining agreement negotiated under this section. The financial contributions by the state must be held in trust for the purpose of paying, from principal, income, or both, the costs associated with creating, implementing, and administering a defined contribution or other individual account retirement program for individual providers of direct support services working under a collective bargaining agreement and providing services through a covered program under section 256B.0711. A board of trustees composed of an equal number of trustees appointed by the governor and trustees appointed by the exclusive representative under this section must administer, manage, and otherwise jointly control the Minnesota Caregiver Retirement Fund Trust. The trust must not be an agent of either the state or the exclusive representative.

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

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

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

(f) Nothing in this section shall be construed to authorize the creation of a defined benefit retirement plan or program.

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

Sec. 6. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision to read:

Subd. 5. **Compliance education required.** The commissioner must make licensing compliance education available to all license holders operating programs licensed under both this chapter and chapter 245D. The licensing compliance education must include clear and accessible explanations of achieving and maintaining compliance with the relevant licensing requirements under this chapter and chapter 245D.

Sec. 7. Minnesota Statutes 2024, section 245A.06, subdivision 1a, is amended to read:

Subd. 1a. **Correction orders and conditional licenses for programs licensed as home and community-based services.** (a) For programs licensed under both this chapter and chapter 245D, if the license holder operates more than one service site under a single license governed by chapter 245D, the correction order or order of conditional license issued under this section shall be specific to the service site or sites at which the violations of applicable law or rules occurred. The order shall not apply to other service sites governed by chapter 245D and operated by the same license holder unless the commissioner has included in the order the articulable basis for applying the order to another service site.

(b) If the commissioner has issued more than one license to the license holder under this chapter, the ~~conditions imposed~~ order issued under this section shall be specific to the license for the program at which the violations of applicable law or rules occurred and shall not apply to other licenses held by the same license holder if those programs are being operated in substantial compliance with applicable law and rules.

(c) Prior to issuing an order of conditional license under this section to a license holder operating a program licensed under both this chapter and chapter 245D, the commissioner must inform the license holder that the next audit or investigation may lead to an order of conditional license if the provider fails to correct the violations specified in a prior correction order or has any new violations. Nothing in this paragraph limits the commissioner's authority to take immediate action under section 245A.07 to prevent or correct actions by the license holder that imminently endanger the health, safety, or rights of the persons served by the program.

(d) The commissioner may reduce the length of time of a conditional license for a license holder operating a program licensed under both this chapter and chapter 245D if the license holder demonstrates compliance or progress toward compliance before the conditional license period expires.

(e) By January 1, 2026, and annually thereafter, the commissioner must provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over chapter 245D licensing on the number of correction orders and orders of conditional license issued to license holders who operate programs licensed under both this chapter and chapter 245D. The report must include aggregated data on the zip codes of locations, number of employees, license effective dates for any license holders subject to correction orders and orders of conditional license, and the commissioner's efforts to offer collaborative safety process improvements to license holders under section 245A.042 and this subdivision.

Sec. 8. Minnesota Statutes 2024, section 245A.06, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the Department of Human Services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be made in writing and must be postmarked and sent to the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder or submitted in the provider licensing and reporting hub within 20 calendar days from the date the commissioner issued the order through the hub, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration. A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

~~(b) This paragraph applies only to licensed family child care providers. A licensed family child care provider who requests reconsideration of a correction order under paragraph (a) may also request, on a form and in the manner prescribed by the commissioner, that the commissioner expedite the review if:~~

~~(1) the provider is challenging a violation and provides a description of how complying with the corrective action for that violation would require the substantial expenditure of funds or a significant change to their program; and~~

~~(2) describes what actions the provider will take in lieu of the corrective action ordered to ensure the health and safety of children in care pending the commissioner's review of the correction order.~~

(b) Notwithstanding paragraph (a), when a request for reconsideration is denied, the commissioner must offer the option of mediation for a license holder operating a program licensed under both this chapter and chapter 245D, if a license holder further disputes the commissioner's correction order. The costs of the mediation option under this paragraph must be paid by the license holder.

Sec. 9. **[245A.142] EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION PROVISIONAL LICENSURE.**

Subdivision 1. **Definitions.** The definitions in section 256B.0949, subdivision 2, apply to this section.

Subd. 2. **Regulatory powers.** The commissioner shall regulate early intensive developmental and behavioral intervention (EIDBI) agencies pursuant to this section.

Subd. 3. **Provisional license.** (a) Beginning on January 1, 2026, the commissioner shall begin issuing provisional licenses to agencies enrolled under chapter 256B to provide EIDBI services.

(b) Agencies enrolled prior to July 1, 2025, have until March 31, 2026, to submit an application for provisional licensure on the forms and in the manner prescribed by the commissioner.

(c) Beginning April 1, 2026, an agency must not operate if it has not submitted an application for provisional licensure under this section. The commissioner shall disenroll an agency from providing EIDBI services under chapter 256B if the agency fails to submit an application for provisional licensure by March 31, 2026, or a complete application by July 1, 2026.

(d) The commissioner must determine whether a provisional license applicant complies with all applicable rules and laws and either issue a provisional license to the applicant or deny the application by December 31, 2026.

(e) A provisional license is effective until comprehensive EIDBI agency licensure standards are in effect unless the provisional license is revoked.

(f) Beginning January 1, 2027, an agency providing EIDBI services must not operate in Minnesota unless provisionally licensed under this section.

Subd. 4. **Provisional license regulatory functions.** The commissioner may:

(1) enter the physical premises of an agency without advance notice in accordance with section 245A.04, subdivision 5;

(2) investigate reports of maltreatment;

(3) investigate complaints against agencies;

(4) take action on a license pursuant to sections 245A.06 and 245A.07;

(5) deny an application for provisional licensure pursuant to section 245A.05; and

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

Subd. 5. **Provisional license requirements.** A provisional license holder must:

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

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

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

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

(5) comply with section 256B.0949, including exceptions to qualifications, standards, and requirements granted by the commissioner under section 256B.0949, subdivision 17.

Subd. 6. **Reconsideration requests and appeals.** An applicant or provisional license holder has reconsideration and appeal rights under sections 245A.05, 245A.06, and 245A.07.

Subd. 7. **Disenrollment.** The commissioner shall disenroll an agency from providing EIDBI services under chapter 256B if:

(1) the agency's application has been suspended or denied under subdivision 2 or the agency's provisional license has been revoked; and

(2) if the agency appealed the application suspension or denial or the provisional license revocation, the commissioner has issued a final order on the appeal.

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

Sec. 10. Minnesota Statutes 2024, section 245C.16, subdivision 1, is amended to read:

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

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

(1) the recency of the disqualifying characteristic;

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

(3) the number of disqualifying characteristics;

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

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

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

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

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

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

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

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

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

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

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

Sec. 11. Minnesota Statutes 2024, section 245D.091, subdivision 2, is amended to read:

Subd. 2. **Positive support professional qualifications.** A positive support professional providing positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans or successor plans:

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neurocognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or

university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11);

(vi) person with a master's degree or PhD in one of the behavioral sciences or related fields with demonstrated expertise in positive support services, as determined by the person's needs as outlined in the person's assessment summary; ~~or~~

(vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services; or

(viii) person who has completed a competency-based training program as determined by the commissioner.

Sec. 12. Minnesota Statutes 2024, section 245D.091, subdivision 3, is amended to read:

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

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

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

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

(4) have completed a competency-based training program as determined by the commissioner.

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

(1) either have two years of supervised experience conducting functional behavior assessments and designing, implementing, and evaluating effectiveness of positive practices behavior support strategies for people who exhibit challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder, or for those who have obtained a baccalaureate degree in one of the behavioral sciences or related fields, demonstrated expertise in positive support services;

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

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

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2024, section 245D.12, is amended to read:

245D.12 INTEGRATED COMMUNITY SUPPORTS~~; SETTING CAPACITY REPORT~~.

Subdivision 1. **Setting capacity report.** (a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2);

(4) the total number of people who could reside in the living units in the multifamily housing building described in clause (2) and receive integrated community supports; and

(5) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

Subd. 2. **Setting approval moratorium.** (a) The commissioner must not approve an integrated community supports setting for which a setting capacity report was submitted between July 1, 2025, and June 30, 2027.

(b) The commissioner may approve exceptions to the approval moratorium under this subdivision if the commissioner determines:

(1) a new integrated community supports setting is needed to provide integrated community supports for a person requiring hospital-level care;

(2) a new integrated community supports setting is needed for a licensed assisted living facility that is closing or converting from an assisted living facility license to a licensed integrated community supports provider;

(3) a new integrated community supports setting with specialized qualities, including wheelchair accessible units, specialized equipment, or other unique qualities is needed to meet the needs of a client identified by the local county board; or

(4) a new integrated community supports setting has funding from the Minnesota Housing Finance Agency or the United States Department of Housing and Urban Development.

(c) When approving an exception under this subdivision, the commissioner shall consider: the availability of approved integrated community supports settings in the geographic area where the licensee seeks to operate, including the number of living units approved and the total number of people who could reside in the approved living units while receiving integrated community services; the results of a person's choices during the person's annual assessment and service plan review; and the recommendation of the local county board. The approval or denial of an exception by the commissioner is final and is not subject to appeal.

Sec. 14. **[245D.13] OUT-OF-HOME RESPITE CARE SERVICES FOR CHILDREN.**

Subdivision 1. **Licensed setting required.** A license holder with a home and community-based services license providing out-of-home respite care services for children may do so only in a licensed setting, unless exempt under subdivision 2. For the purposes of this section, "respite care services" has the meaning given in section 245A.02, subdivision 15.

Subd. 2. **Exemption from licensed setting requirement.** (a) The exemption under this subdivision does not apply to the provision of respite care services to a child in foster care under chapter 260C or 260D.

(b) A license holder with a home and community-based services license may provide out-of-home respite care services for children in an unlicensed residential setting if:

(1) all background studies are completed according to the requirements in chapter 245C;

(2) a child's case manager conducts and documents an assessment of the residential setting and its environment before services are provided and at least once each calendar year thereafter if services continue to be provided at that residence. The assessment must ensure that the setting is suitable for the child receiving respite care services. The assessment must be conducted and documented in the manner prescribed by the commissioner;

(3) the child's legal representative visits the residence and signs and dates a statement authorizing services in the residence before services are provided and at least once each calendar year thereafter if services continue to be provided at that residence;

(4) the services are provided in a residential setting that is not licensed to provide any other licensed services;

(5) the services are provided to no more than four children at any one time. Each child must have an individual bedroom, except two siblings may share a bedroom;

(6) the services are not provided to children and adults over the age of 21 in the same residence at the same time;

(7) the services are not provided to a single family for more than 46 calendar days in a calendar year and no more than ten consecutive days;

(8) the license holder's license was not made conditional, suspended, or revoked during the previous 24 months; and

(9) each individual in the residence at the time services are provided, other than individuals receiving services, is an employee, as defined under section 245C.02, of the license holder and has had a background study completed under chapter 245C. No other household members or other individuals may be present in the residence while services are provided.

(c) A child may not receive out-of-home respite care services in more than two unlicensed residential settings in a calendar year.

(d) The license holder must ensure the requirements in this section are met.

Subd. 3. **Documentation requirements.** The license holder must maintain documentation of the following:

(1) background studies completed under chapter 245C;

(2) service recipient records indicating the calendar dates and times when services were provided;

(3) the case manager's initial residential setting assessment and each residential assessment completed thereafter; and

(4) the legal representative's approval of the residential setting before services are provided and each year thereafter.

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

Sec. 15. Minnesota Statutes 2024, section 252.32, subdivision 3, is amended to read:

Subd. 3. **Amount of support grant; use.** (a) Support grant amounts shall be determined by the county social service agency. Services and items purchased with a support grant must:

(1) be over and above the normal costs of caring for the dependent if the dependent did not have a disability, including adaptive or one-on-one swimming lessons for drowning prevention for a dependent younger than 12 years of age whose disability puts the dependent at a higher risk of drowning according to the Centers for Disease Control Vital Statistics System;

(2) be directly attributable to the dependent's disabling condition; and

(3) enable the family to delay or prevent the out-of-home placement of the dependent.

(b) The design and delivery of services and items purchased under this section must be provided in the least restrictive environment possible, consistent with the needs identified in the individual service plan.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the family. Fees assessed to parents for health or human services that are funded by federal, state, or county dollars are not reimbursable through this program.

(d) In approving or denying applications, the county shall consider the following factors:

(1) the extent and areas of the functional limitations of a child with a disability;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment.

(e) The maximum monthly grant amount shall be $250 per eligible dependent, or $3,000 per eligible dependent per state fiscal year, within the limits of available funds and as adjusted by any legislatively authorized cost of living adjustment. The county social service agency may consider the dependent's Supplemental Security Income in determining the amount of the support grant.

(f) Any adjustments to their monthly grant amount must be based on the needs of the family and funding availability.

Sec. 16. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 30a. **State certified MnCHOICES assessor team.** (a) To facilitate the timely processing of long-term care consultation assessments under section 256B.0911, the commissioner must establish and maintain a team of assessors certified according to section 256B.0911, subdivision 13. Members of the state assessment team are authorized to conduct assessments under section 256B.0911 throughout the state. The commissioner may deploy members of the state assessment team to lead agencies with significant backlogs of pending or incomplete long-term care consultation assessments to temporarily supplement the capacity of the lead agency.

(b) The commissioner may deploy a state assessment team member to a hospital, nursing facility, intermediate care facility, or state-operated facility to expedite an assessment of a person who:

(1) is awaiting release or discharge because the person does not meet the applicable admission criteria or level of care criteria for the setting, but the setting cannot identify a setting to which the patient could be safely released or discharged without an assessment; or

(2) requests transition assistance under section 256B.0911, subdivision 27 or 28.

If the commissioner deploys a state assessment team member under this paragraph, the commissioner may require any organization receiving grant funds from the MNsure board of directors that support the organization's medical assistance and MinnesotaCare enrollment work to deploy an in-person assistor or navigator to assist the person being assessed in expediting the person's application for medical assistance or MinnesotaCare.

(c) Nothing in the subdivision shall be construed to relieve a lead agency of its obligations under section 256B.0911, subdivision 14, paragraph (b), to have sufficient numbers of certified assessors employed by the lead agency or under contract with the lead agency to provide long-term consultation assessment and support planning within the timelines and parameters required under section 256B.0911.

Sec. 17. Minnesota Statutes 2024, section 256.476, subdivision 4, is amended to read:

Subd. 4. **Support grants; criteria and limitations.** (a) A county board may choose to participate in the consumer support grant program. If a county has not chosen to participate by July 1, 2002, the commissioner shall contract with another county or other entity to provide access to residents of the nonparticipating county who choose the consumer support grant option. The commissioner shall notify the county board in a county that has declined to participate of the commissioner's intent to enter into a contract with another county or other entity at least 30 days in advance of entering into the contract. The local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 11.

(b) Support grants to a person, a person's legal representative, or other authorized representative will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations, including adaptive or one-on-one swimming lessons for drowning prevention for a person younger than 12 years of age whose disability puts the person at a higher risk of drowning according to the Centers for Disease Control Vital Statistics System;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person, a person's legal representative, or other authorized representative to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service agreement, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person, a person's legal representative, or other authorized representative. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person, a person's legal representative, or other authorized representative shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, or other authorized representative, if any. The application shall be made to the local agency and shall specify the needs of the person or the person's legal representative or other authorized representative, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or the person's legal representative or other authorized representative, the local agency shall make grants to the person or the person's legal representative or other authorized representative. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's legal representative or other authorized representative.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.035.

Sec. 18. Minnesota Statutes 2024, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E. A provider must enroll each provider-controlled location where direct services are provided. The commissioner may deny a provider's incomplete application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request. The commissioner must conduct a background study under chapter 245C, including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider described in this paragraph. The background study requirement may be satisfied if the commissioner conducted a fingerprint-based background study on the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

(b) The commissioner shall revalidate ~~each~~:

(1) each provider under this subdivision at least once every five years; ~~and~~

(2) each personal care assistance agency, CFSS provider-agency, and CFSS financial management services provider under this subdivision at least once every three years~~.~~;

(3) each EIDBI agency under this subdivision at least once every three years; and

(4) at the commissioner's discretion, any medical-assistance-only provider type the commissioner deems "high risk" under this subdivision.

(c) The commissioner shall conduct revalidation as follows:

(1) provide 30-day notice of the revalidation due date including instructions for revalidation and a list of materials the provider must submit;

(2) if a provider fails to submit all required materials by the due date, notify the provider of the deficiency within 30 days after the due date and allow the provider an additional 30 days from the notification date to comply; and

(3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day notice of termination and immediately suspend the provider's ability to bill. The provider does not have the right to appeal suspension of ability to bill.

(d) If a provider fails to comply with any individual provider requirement or condition of participation, the commissioner may suspend the provider's ability to bill until the provider comes into compliance. The commissioner's decision to suspend the provider is not subject to an administrative appeal.

(e) Correspondence and notifications, including notifications of termination and other actions, may be delivered electronically to a provider's MN-ITS mailbox. This paragraph does not apply to correspondences and notifications related to background studies.

(f) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(g) An enrolled provider that is also licensed by the commissioner under chapter 245A, is licensed as a home care provider by the Department of Health under chapter 144A, or is licensed as an assisted living facility under chapter 144G and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(h) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or

referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(i) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state. The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under this paragraph, if the agency:

(1) is unable to retain Medicare certification and enrollment solely due to a lack of billing to the Medicare program;

(2) meets all other applicable Medicare certification requirements based on an on-site review completed by the commissioner of health; and

(3) serves primarily a pediatric population.

(j) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(k) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3),

operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(m) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (f) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

Sec. 19. Minnesota Statutes 2024, section 256B.0659, subdivision 17a, is amended to read:

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

personal care assistant who meets the requirements of subdivision 11, paragraph (d). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for ten or more hours of personal care assistance services per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d).

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

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

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

Sec. 20. Minnesota Statutes 2024, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including long-term care consultation assessment and support planning, is also intended to prevent or delay institutional placements and to provide access to transition assistance after placement. Further, the goal of long-term care consultation services is to contain costs associated with unnecessary institutional admissions. Long-term care consultation services must be available to any person regardless of public program eligibility.

(b) The commissioner of human services shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(c) Long-term care consultation services must be coordinated with long-term care options counseling, long-term care options counseling ~~for assisted living~~ at critical care transitions, the Disability Hub, and preadmission screening.

(d) A lead agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 21. Minnesota Statutes 2024, section 256B.0911, subdivision 10, is amended to read:

Subd. 10. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(c) "Competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(d) "Cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program.

(e) "Independent living" means living in a setting that is not controlled by a provider.

(f) "Informed choice" has the meaning given in section 256B.4905, subdivision 1a.

(g) "Lead agency" means a county administering or a Tribe or health plan under contract with the commissioner to administer long-term care consultation services.

(h) "Long-term care consultation services" means the activities described in subdivision 11.

(i) "Long-term care options counseling" means the services provided by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow-up after a long-term care consultation assessment has been completed.

(j) "Long-term care options counseling ~~for assisted living~~ at critical care transitions" means the services provided under section 256.975, ~~subdivisions~~ subdivision 7e ~~to 7g~~.

(k) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(l) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(m) "Preadmission screening" means the services provided under section 256.975, subdivisions 7a to 7c.

Sec. 22. Minnesota Statutes 2024, 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 have received training and certification specific to assessment and consultation for long-term care services in the state and either:

(1) ~~either~~ have ~~a bachelor's~~ at least an associate's degree in ~~social work,~~ human services, or other closely related field;

(2) have at least an associate's degree in nursing with a public health nursing certificate, or other closely related field; or

(3) be a registered nurse~~; 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. 23. Minnesota Statutes 2024, section 256B.0911, subdivision 14, is amended to read:

Subd. 14. **Use of MnCHOICES certified assessors required.** (a) Each lead agency shall use MnCHOICES certified assessors who have completed MnCHOICES training and the certification process determined by the commissioner in subdivision 13.

(b) Each lead agency must ensure that the lead agency has sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service.

(c) A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) A lead agency must provide the commissioner with an administrative contact for communication purposes.

(f) A lead agency may contract under this subdivision with any hospital licensed under sections 144.50 to 144.56 to conduct assessments of patients in the hospital on behalf of the lead agency when the lead agency has failed to meet its obligations under subdivision 17. The contracted assessment must be conducted by a hospital employee who is a qualified, certified assessor. The hospital employees who perform assessments under the contract between the hospital and the lead agency may perform assessments in addition to other duties assigned to the employee by the hospital, except the hospital employees who perform the assessments under contract with the lead agency must not perform any waiver-related tasks other than assessments. Hospitals are not eligible for reimbursement under subdivision 33. The lead agency that enters into a contract with a hospital under this paragraph is responsible for oversight, compliance, and quality assurance for all assessments performed under the contract.

Sec. 24. Minnesota Statutes 2024, section 256B.0911, subdivision 24, is amended to read:

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

(b) For services provided by the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care,

and brain injury waiver programs under section 256B.49, remote reassessments may be substituted for ~~two~~ four consecutive reassessments if followed by an in-person reassessment.

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

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 2024, section 256B.0911, is amended by adding a subdivision to read:

Subd. 24a. **Verbal attestation to replace required reassessment signatures.** Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner shall allow for verbal attestation to replace required reassessment signatures.

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

Sec. 26. Minnesota Statutes 2024, section 256B.0911, is amended by adding a subdivision to read:

Subd. 25a. **Attesting to no changes in needs or services.** (a) A person who is older than 21 years of age, under 65 years of age, and receiving home and community-based waiver services under the developmental disabilities waiver program under section 256B.092; community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49; or community first services and supports under section 256B.85 may attest that the person has unchanged needs from the most recent prior assessment or reassessment for up to two consecutive reassessments if the lead agency provides informed choice and the person being reassessed or the person's legal representative provides informed consent. Lead agencies must document that informed choice was offered.

(b) The person or person's legal representative must attest, verbally or through alternative communications, that the information provided in the previous assessment or reassessment is still accurate and applicable and that no changes in the person's circumstances have occurred that would require changes from the most recent prior assessment or reassessment. The person or the person's legal representative may request a full reassessment at any time.

(c) The assessor must review the most recent prior assessment or reassessment as required in subdivision 22, paragraphs (a) and (b), clause (1), before conducting the interview. The certified assessor must confirm that the information from the previous assessment or reassessment is current.

(d) The assessment conducted under this section must:

(1) verify current assessed support needs;

(2) confirm continued need for the currently assessed level of care;

(3) inform the person of alternative long-term services and supports available;

(4) provide informed choice of institutional or home and community-based services; and

(5) identify changes in need that may require a full reassessment.

(e) The assessor must ensure that any new assessment items or requirements mandated by federal or state authority are addressed and the person must provide required information.

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. 27. Minnesota Statutes 2024, section 256B.0911, subdivision 26, is amended to read:

Subd. 26. **Determination of institutional level of care.** (a) The determination of need for hospital and intermediate care facility levels of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner.

(b) The determination of need for nursing facility level of care must be made based on criteria in section 144.0724, subdivision 11. This paragraph expires upon the effective date of paragraph (c).

(c) Effective January 1, 2026, or upon federal approval, whichever is later, the determination of need for nursing facility level of care must be made based on criteria in section 144.0724, subdivision 11, except for determinations of need for purposes of the brain injury and community access for disability inclusion waivers under section 256B.49.

(d) Determinations of need for the purposes of the brain injury and community access for disability inclusion waivers must be made based on criteria in section 144.0724, subdivision 11a. If a person is found ineligible for waiver services under this paragraph because of a determination that the person does not meet the criteria in section 144.0724, subdivision 11a, the lead agency must review the person's latest assessment under section 256B.0911 to determine if the person meets any of the nursing facility level of care criteria under section 144.0724, subdivision 11. If the lead agency determines after the review that the person does meet a nursing facility level of care criteria under section 144.0724, subdivision 11, the lead agency must provide a notice of action to the person informing the person specifically that the person's waiver services are being terminated because the person meets only a nursing facility level of care of under section 144.0724, subdivision 11, that is no longer a basis for waiver eligibility. The lead agency must also inform the person of other benefits options for which the person may be eligible. For existing waiver participants, the effective date of the termination of waiver services based on this paragraph must be no sooner than 90 days after the date of the assessment under section 256B.0911.

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

Sec. 28. Minnesota Statutes 2024, section 256B.0911, is amended by adding a subdivision to read:

Subd. 35. **Dashboard on assessment completions.** (a) The commissioner shall maintain a dashboard on the department's public website containing summary data on the completion

of assessments under this section. The commissioner must update the dashboard at least twice per year.

(b) The dashboard must include:

(1) the total number of assessments performed since the previous reporting period, by lead agency;

(2) the total number of initial assessments performed since the previous reporting period, by lead agency;

(3) the total number of reassessments performed since the previous reporting period, by lead agency;

(4) the number and percentage of assessments completed within the required timeline, by a lead agency;

(5) the average length of time to complete an assessment, by a lead agency;

(6) summary data of the location in which the assessments were performed, by lead agency; and

(7) other information the commissioner determines is valuable to assess the capacity of lead agencies to complete assessments within the timelines prescribed by law.

Sec. 29. Minnesota Statutes 2024, section 256B.0911, is amended by adding a subdivision to read:

Subd. 36. **Cooperation with state certified MnCHOICES assessor teams.** (a) In the event that the commissioner deploys state certified assessors under section 256.01, subdivision 30a, to temporarily supplement the capacity of the lead agency to perform long-term care consultation assessments and to meet its obligations under this section, the lead agency must cooperate with the commissioner and the state assessor team to implement a work plan to reduce the backlog and improve both training of lead agency staff and processes to minimize future backlogs.

(b) In the event that the commissioner deploys state certified assessors under section 256.01, subdivision 30a, to perform an expedited long-term care consultation assessment under section 256.01, subdivision 30a, at the request of the state assessor, the lead agency must ensure that the person is visited by lead agency staff within five days of the visit by the state assessor to begin the process of determining financial eligibility for medical assistance.

Sec. 30. Minnesota Statutes 2024, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact either in person or by interactive video that meets the requirements in section 256B.0625, subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

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

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

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

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as

defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

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

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

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

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2024, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this subdivision.

(b) "Advanced certification" means a person who has completed advanced certification in an approved modality under subdivision 13, paragraph (b).

(c) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI services and that has the legal responsibility to ensure that its employees ~~or contractors~~ carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

(d) "Autism spectrum disorder or a related condition" or "ASD or a related condition" means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of a person with ASD;

(3) requires treatment or services similar to those required for a person with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social or interpersonal interaction; functional communication, including nonverbal or social communication; and restrictive or repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains:

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

(e) "Person" means a person under 21 years of age.

(f) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, individual treatment plan progress monitoring, and treatment review for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee and the clinical effectiveness of all interventions.

(g) "Commissioner" means the commissioner of human services, unless otherwise specified.

(h) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a person to determine medical necessity for EIDBI services based on the requirements in subdivision 5.

(i) "Department" means the Department of Human Services, unless otherwise specified.

(j) "Early intensive developmental and behavioral intervention benefit" or "EIDBI benefit" means a variety of individualized, intensive treatment modalities approved and published by the commissioner that are based in behavioral and developmental science consistent with best practices on effectiveness.

(k) "Employee" means any person who is employed by an agency, including temporary and part-time employees, and who performs work for at least 80 hours in a year for that agency in Minnesota. Employee does not include an independent contractor.

~~(k)~~ (l) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and people, and in different environments including, but not limited to, clinics, homes, schools, and the community.

~~(l)~~ (m) "Incident" means when any of the following occur:

(1) an illness, accident, or injury that requires first aid treatment;

(2) a bump or blow to the head; or

(3) an unusual or unexpected event that jeopardizes the safety of a person or staff, including a person leaving the agency unattended.

~~(m)~~ (n) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. An individual treatment plan must meet the standards in subdivision 6.

~~(n)~~ (o) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

~~(o)~~ (p) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

~~(p)~~ (q) "Person-centered" means a service that both responds to the identified needs, interests, values, preferences, and desired outcomes of the person or the person's legal representative and respects the person's history, dignity, and cultural background and allows inclusion and participation in the person's community.

~~(q)~~ (r) "Qualified EIDBI provider" means a person who is a QSP or a level I, level II, or level III treatment provider.

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

Sec. 32. Minnesota Statutes 2024, section 256B.0949, subdivision 13, is amended to read:

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are eligible for reimbursement by medical assistance under this section. Services must be provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must address the person's medically necessary treatment goals and must be targeted to develop, enhance, or maintain the individual developmental skills of a person with ASD or a related condition to improve functional communication, including nonverbal or social communication, social or interpersonal interaction, restrictive or repetitive behaviors, hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation, cognition, learning and play, self-care, and safety.

(b) EIDBI treatment must be delivered consistent with the standards of an approved modality, as published by the commissioner. EIDBI modalities include:

(1) applied behavior analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM); or

~~(4) PLAY project;~~

~~(5)~~ (4) relationship development intervention (RDI)~~; or~~.

~~(6) additional modalities not listed in clauses (1) to (5) upon approval by the commissioner.~~

(c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b), clauses (1) to ~~(5)~~ (4), as the primary modality for treatment as a covered service, or several EIDBI modalities in combination as the primary modality of treatment, as approved by the commissioner. An EIDBI provider that identifies and provides assurance of qualifications for a single specific treatment modality, including an EIDBI provider with advanced certification overseeing implementation, must document the required qualifications to meet fidelity to the specific model in a manner determined by the commissioner.

(d) Each qualified EIDBI provider must identify and provide assurance of qualifications for professional licensure certification, or training in evidence-based treatment methods, and must document the required qualifications outlined in subdivision 15 in a manner determined by the commissioner.

(e) CMDE is a comprehensive evaluation of the person's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(f) EIDBI intervention observation and direction is the clinical direction and oversight of EIDBI services by the QSP, level I treatment provider, or level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a person. EIDBI intervention observation and direction informs any modification of the current treatment protocol to support the outcomes outlined in the ITP.

(g) Intervention is medically necessary direct treatment provided to a person with ASD or a related condition as outlined in their ITP. All intervention services must be provided under the direction of a QSP. Intervention may take place across multiple settings. The frequency and intensity of intervention services are provided based on the number of treatment goals, person and family or caregiver preferences, and other factors. Intervention services may be provided individually or in a group. Intervention with a higher provider ratio may occur when deemed medically necessary through the person's ITP.

(1) Individual intervention is treatment by protocol administered by a single qualified EIDBI provider delivered to one person.

(2) Group intervention is treatment by protocol provided by one or more qualified EIDBI providers, delivered to at least two people who receive EIDBI services.

(3) Higher provider ratio intervention is treatment with protocol modification provided by two or more qualified EIDBI providers delivered to one person in an environment that meets the person's needs and under the direction of the QSP or level I provider.

(h) ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents provide oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrate and coordinate the person's and the person's legal representative's information from the CMDE and ITP progress monitoring. This service must be reviewed and completed by the QSP, and may include input from a level I provider or a level II provider.

(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.

(j) A coordinated care conference is a voluntary meeting with the person and the person's family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP. This service may include the CMDE provider, QSP, a level I provider, or a level II provider.

(k) Travel time is allowable billing for traveling to and from the person's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide in-person EIDBI intervention, observation and direction, or family caregiver training and counseling. The person's ITP must specify the reasons the provider must travel to the person.

(l) Medical assistance covers medically necessary EIDBI services and consultations delivered via telehealth, as defined under section 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered in person.

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

Sec. 33. Minnesota Statutes 2024, section 256B.0949, subdivision 15, is amended to read:

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

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

ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 34. Minnesota Statutes 2024, section 256B.0949, subdivision 16, is amended to read:

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

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

(2) designate an individual as the agency's compliance officer who must perform the duties described in section 256B.04, subdivision 21, paragraph (g);

(3) demonstrate compliance with federal and state laws for the delivery of and billing for EIDBI service;

~~(3)~~ (4) verify and maintain records of a service provided to the person or the person's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

~~(4)~~ (5) demonstrate that while enrolled or seeking enrollment as a Minnesota health care program provider the agency did not have a lead agency contract or provider agreement discontinued because of a conviction of fraud; or did not have an owner, board member, or manager fail a state or federal criminal background check or appear on the list of excluded individuals or entities maintained by the federal Department of Human Services Office of Inspector General;

~~(5)~~ (6) have established business practices including written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality EIDBI services, appropriately submit claims, conduct required staff training, document staff qualifications, document service activities, and document service quality;

~~(6)~~ (7) have an office located in Minnesota or a border state;

~~(7) conduct a criminal background check on an individual who has direct contact with the person or the person's legal representative~~ (8) initiate a background study as required under subdivision 16a;

~~(8)~~ (9) report maltreatment according to section 626.557 and chapter 260E;

~~(9)~~ (10) comply with any data requests consistent with the Minnesota Government Data Practices Act, sections 256B.064 and 256B.27;

~~(10)~~ (11) provide training for all agency staff on the requirements and responsibilities listed in the Maltreatment of Minors Act, chapter 260E, and the Vulnerable Adult Protection Act, section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's policy for all staff on how to report suspected abuse and neglect;

~~(11)~~ (12) have a written policy to resolve issues collaboratively with the person and the person's legal representative when possible. The policy must include a timeline for when the person and the person's legal representative will be notified about issues that arise in the provision of services;

~~(12)~~ (13) provide the person's legal representative with prompt notification if the person is injured while being served by the agency. An incident report must be completed by the agency staff member in charge of the person. A copy of all incident and injury reports must remain on file at the agency for at least five years from the report of the incident; ~~and~~

~~(13)~~ (14) before starting a service, provide the person or the person's legal representative a description of the treatment modality that the person shall receive, including the staffing certification levels and training of the staff who shall provide a treatment~~.~~;

(15) provide clinical supervision for a minimum of one hour for every 20 hours of direct treatment per person; and

(16) provide clinical supervision sessions at least once per month for EIDBI intervention observation and direction. Notwithstanding subdivision 13, paragraph (l), clinical supervision sessions under this clause may be conducted via telehealth provided:

(i) the telehealth clinical supervision session is conducted in tandem with a level I or level II provider who is in person and not billing for any EIDBI services; and

(ii) no more than two consecutive monthly clinical supervision sessions under this clause are conducted via telehealth.

(b) Upon request of the commissioner, an agency delivering services under this section must:

(1) identify the agency's controlling individuals, as defined under section 245A.02, subdivision 5a;

(2) provide disclosures of the use of billing agencies and other consultants; and

(3) provide copies of any contracts with independent contractors for qualified supervising professionals, including hours contracted and responsibilities.

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

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

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

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

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

Sec. 35. Minnesota Statutes 2024, section 256B.0949, subdivision 16a, is amended to read:

Subd. 16a. **Background studies.** An early intensive developmental and behavioral intervention services agency must fulfill any background studies requirements under this section by initiating a background study through the commissioner's NETStudy 2.0 system as provided under sections 245C.03, subdivision 15~~, and 245C.10, subdivision 17~~. Before an individual subject to the background study requirements under this subdivision has direct contact with the person, the agency must have received a notice from the commissioner that the subject of the background study is:

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

(2) disqualified but the subject of the study has received a set-aside of the disqualification under section 245C.22.

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

Sec. 36. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision to read:

Subd. 18. **Site visits and sanctions.** (a) The commissioner may conduct unannounced on-site inspections of any and all EIDBI agencies and service locations to verify that information submitted to the commissioner is accurate, determine compliance with all enrollment requirements, investigate reports of maltreatment, determine compliance with service delivery and billing requirements, and determine compliance with any other applicable laws or rules.

(b) The commissioner may withhold payment from an agency or suspend or terminate the agency's enrollment number if the agency fails to provide access to the agency's service locations or records or the commissioner determines the agency has failed to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

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

Sec. 37. Minnesota Statutes 2024, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined ~~likely~~ to require the level of care provided in a nursing facility as determined under section 256B.0911, subdivision 26, or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 38. Minnesota Statutes 2024, 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. If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred

language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) 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.

(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 20 hours of case management education and disability-related training each year. The education and training must include appropriate service authorization under the community access for disability inclusion waiver, 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 of human services. 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.

Sec. 39. Minnesota Statutes 2024, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) life sharing;

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

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

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

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

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

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

~~(20) respite services;~~

~~(21)~~ (22) transportation services; and

~~(22)~~ (23) other services as approved by the federal government in the state home and community-based services waiver plan.

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

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

Sec. 40. Minnesota Statutes 2024, section 256B.4914, subdivision 5, is amended to read:

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

(b) The commissioner shall update the base wage index in subdivision 5a, publish these updated values, and load them into the rate management system ~~as follows:~~ on January 1, 2030, and every two years thereafter, based on wage data by SOC from the Bureau of Labor Statistics published in the spring approximately 21 months prior to the scheduled update.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 42. Minnesota Statutes 2024, section 256B.4914, subdivision 5b, is amended to read:

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

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

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

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

(b) The commissioner shall update the base wage index under subdivision 5a 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 on January 1, 2026, and January 1, 2028, by the percentage change in the CPI-U from the date of the previous update to the data available 24 months and one day prior to the scheduled update. This paragraph expires December 31, 2029.

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

Sec. 43. Minnesota Statutes 2024, section 256B.4914, subdivision 6a, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

(7) combine the results of clauses (5) and (6), excluding any shared direct staffing and individual direct staffing hours provided through monitoring technology, and multiply the

result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

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

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

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

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

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

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

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

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

Sec. 44. Minnesota Statutes 2024, section 256B.4914, subdivision 6b, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) general administrative support ratio: 3.3 percent;

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

(7) absence factor: 1.7 percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 45. Minnesota Statutes 2024, section 256B.4914, subdivision 6c, is amended to read:

Subd. 6c. **Integrated community supports; component values and calculation of payment rates.** (a) Component values for integrated community supports are:

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

(b) Payments for integrated community supports must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs. The base shared direct staffing hours must be eight hours divided by the number of people receiving support in the integrated community support setting, and the individual direct staffing hours must be the average number of direct support hours provided directly to the service recipient;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours in clause (1) by the appropriate staff wages;

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

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

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

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

(10) add the results of clauses (8) and (9);

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

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

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

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

Sec. 46. Minnesota Statutes 2024, section 256B.4914, subdivision 7a, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. The amendments to paragraph (a), clause (1), are effective the day following final enactment.

Sec. 47. Minnesota Statutes 2024, section 256B.4914, subdivision 7b, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. The amendments to paragraph (a), clause (1), are effective the day following final enactment.

Sec. 48. Minnesota Statutes 2024, section 256B.4914, subdivision 7c, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. The amendments to paragraph (a), clause (1), are effective the day following final enactment.

Sec. 49. Minnesota Statutes 2024, section 256B.4914, subdivision 8, is amended to read:

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

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 15.5 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

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

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

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

(e) Effective January 1, 2026, or upon federal approval, whichever is later, providers must not bill more than nine hours per day for individualized home supports with training

and individualized home supports with family training. This maximum does not limit a person's use of other disability waiver services.

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

Sec. 50. Minnesota Statutes 2024, section 256B.4914, subdivision 9, is amended to read:

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

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

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

Sec. 51. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

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

(b) The commissioner must restrict rate exceptions to the absence and utilization factor ratio to people temporarily receiving hospital or crisis respite services.

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

(1) a documented behavioral diagnosis; or

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

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

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

(f) For the commissioner to approve a rate exception annual renewal, the person's most recent assessment must indicate continued extraordinary needs in the areas cited in the exception request. If a person's assessment continues to identify these extraordinary needs, lead agencies requesting an annual renewal of rate exceptions must submit provider-created documentation supporting the continuation of the exception, including but not limited to:

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

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

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

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

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

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

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

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

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

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

Sec. 52. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

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

Sec. 53. Minnesota Statutes 2024, section 256B.85, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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

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

(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

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

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

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

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

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

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

(5) insertion and maintenance of catheter, including:

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

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

(iii) bladder irrigations;

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

(7) neurological intervention, including:

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

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

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

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish

the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

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

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

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

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

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

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

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

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking;

shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community, including traveling to medical appointments. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the individual CFSS service delivery plan.

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

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

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

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

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 54. Minnesota Statutes 2024, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivisions 17 to 21, 23, 24, and 29 to 31;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and

supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

(3) be completed using the format established by the commissioner.

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's assessor as defined in section 256B.0911 to the participant or the participant's representative and chosen CFSS providers within ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

~~(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in this subdivision. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in this subdivision and participants must use consultation services to complete their orientation and selection of a service model.~~

Sec. 55. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

Subd. 5a. **Temporary authorization without assessment.** The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in subdivision 5. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this subdivision shall have no bearing on a future authorization. For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in subdivision 5 and participants must use consultation services to complete their orientation and selection of a service model.

Sec. 56. Minnesota Statutes 2024, section 256B.85, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

(6) swimming lessons for a participant younger than 12 years of age whose disability puts the participant at a higher risk of drowning according to the Centers for Disease Control Vital Statistics System;

~~(6)~~ (7) services described under subdivision 17 provided by a consultation services provider ~~as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider~~ meeting the requirements of subdivision 17a;

~~(7)~~ (8) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

~~(8)~~ (9) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. Covered services under this clause are subject to the limitations described in subdivision 7b; and

~~(9)~~ (10) worker training and development services as described in subdivision 18a.

EFFECTIVE DATE. This section is effective July 1, 2025, 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. Minnesota Statutes 2024, section 256B.85, subdivision 7a, is amended to read:

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

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). This paragraph expires upon the effective date of paragraph (c).

(c) Effective January 1, 2027, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day.

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

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

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

Sec. 58. Minnesota Statutes 2024, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's

designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

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

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

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

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

(3) the presence of Level I behavior.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) an adjustment needed for administrative expenses.

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

Sec. 59. Minnesota Statutes 2024, section 256B.85, subdivision 8a, is amended to read:

Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the commissioner or the commissioner's designee as described in subdivision 8 except when:

(1) the lead agency temporarily authorizes services in the agency-provider model as described in subdivision ~~5, paragraph (c)~~ 5a;

(2) CFSS services in the agency-provider model were required to treat an emergency medical condition that if not immediately treated could cause a participant serious physical or mental disability, continuation of severe pain, or death. The CFSS agency provider must request retroactive authorization from the lead agency no later than five working days after providing the initial emergency service. The CFSS agency provider must be able to substantiate the emergency through documentation such as reports, notes, and admission or discharge histories. A lead agency must follow the authorization process in subdivision 5 after the lead agency receives the request for authorization from the agency provider;

(3) the lead agency authorizes a temporary increase to the amount of services authorized in the agency or budget model to accommodate the participant's temporary higher need for services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this clause shall have no bearing on a future authorization;

(4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for CFSS services is completed based on the date of a current assessment, eligibility, and request for authorization;

(5) a third-party payer for CFSS services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(6) the commissioner has determined that a lead agency or state human services agency has made an error; or

(7) a participant enrolled in managed care experiences a temporary disenrollment from a health plan, in which case the commissioner shall accept the current health plan authorization for CFSS services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension

of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

Sec. 60. Minnesota Statutes 2024, section 256B.85, subdivision 11, is amended to read:

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

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

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

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

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

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

(g) Participants purchasing goods under ~~this~~ the agency-provider model, along with support worker services, must:

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

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

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

Sec. 61. Minnesota Statutes 2024, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use consultation services specified in subdivision 17 and services specified in subdivision 13a provided by an FMS provider. Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, family and medical benefit insurance, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) If two or more participants using the budget model live in the same household and have the same support worker, the participants must use the same FMS provider.

(d) If the FMS provider advises that there is a joint employer in the budget model, all participants associated with that joint employer must use the same FMS provider.

(e) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under, but not limited to, the following circumstances:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative is unable to fulfill the responsibilities under the budget model, as specified in subdivision 14.

(f) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph (e), clause (3), to disenroll or exclude the participant from the budget model.

Sec. 62. Minnesota Statutes 2024, section 256B.85, subdivision 16, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) A support worker must not provide or be paid for more than 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

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

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

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements. This paragraph expires December 31, 2026.

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

Sec. 63. Minnesota Statutes 2024, section 256B.85, subdivision 17a, is amended to read:

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) ~~are~~ be under contract with the department and enrolled as a Minnesota health care program provider;

(3) ~~are not~~ not be the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the consultation service provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(6) employ lead professional staff with a minimum of two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(7) report maltreatment as required under chapter 260E and section 626.557;

(8) comply with medical assistance provider requirements;

(9) understand the CFSS program and its policies;

(10) ~~are~~ be knowledgeable about self-directed principles and the application of the person-centered planning process;

(11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

(12) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Sec. 64. Minnesota Statutes 2024, section 256B.851, subdivision 5, is amended to read:

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

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

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

(3) employee benefits factor, 12.04 percent;

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

(5) program plan support factor, 7.00 percent;

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

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

(8) absence and utilization factor, 3.90 percent.

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

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

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

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

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

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

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

(3) qualified professional services and CFSS worker training and development: 92.08 percent. This paragraph expires upon the effective date of subdivision 5a.

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

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

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

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

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

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

~~(e)~~ (d) The commissioner shall define the appropriate worker retention component under subdivision 5b or 5c 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. This section is effective the day following final enactment.

Sec. 65. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5a. **Payment rates; implementation factor.** Effective January 1, 2026, or upon federal approval, whichever is later, for purposes of implementation, the commissioner shall use the following implementation components:

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

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

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

Sec. 66. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5b. **Payment rates; worker retention component.** Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner shall use the following worker retention components:

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

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

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

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

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

Sec. 67. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5c. **Payment rates; enhanced worker retention component.** Effective January 1, 2027, or upon federal approval, whichever is later, the commissioner shall use the following worker retention components if a worker has completed either the orientation for individual providers offered through the Home Care Orientation Trust or an orientation defined and offered by the commissioner:

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

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

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

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

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

Sec. 68. Minnesota Statutes 2024, section 256B.851, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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. 69. Minnesota Statutes 2024, section 256B.851, subdivision 7, is amended to read:

Subd. 7. **Treatment of rate adjustments provided outside of cost components.** Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section, including but not limited to those implemented to enable participant-employers and provider agencies to meet the terms and conditions of any collective bargaining agreement negotiated under chapter 179A, shall be applied as changes to the value of component values ~~or~~, implementation components, or worker retention components in ~~subdivision~~ subdivisions 5 to 5c.

Sec. 70. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 7a. **Budget determinations.** The commissioner shall increase the authorized amount for the CFSS budget model of those CFSS participant-employers employing individual providers who have provided more than 1,000 hours of services and individual providers who have completed the orientation offered by the Home Care Orientation Trust or an orientation defined and offered by the commissioner. The commissioner shall determine the amount and method of the authorized amount increase.

Sec. 71. Minnesota Statutes 2024, section 260E.14, subdivision 1, is amended to read:

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

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

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

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under sections 245A.142 and 256B.0949.

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

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

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

Sec. 72. Minnesota Statutes 2024, section 626.5572, subdivision 13, is amended to read:

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

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

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs, mental health clinics, substance use disorder programs,

the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949.

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

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

Sec. 73. Laws 2021, First Special Session chapter 7, article 13, section 73, is amended to read:

Sec. 73. **WAIVER REIMAGINE PHASE II.**

(a) Effective January 1, 2027, or upon federal approval, whichever is later, the commissioner of human services must implement a two-home and community-based services waiver program structure, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(b) The commissioner of human services must implement an individualized budget methodology, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(c) The commissioner must develop an individualized budget methodology exception to support access to self-directed home care nursing services. Lead agencies must submit budget exception requests to the commissioner in a manner identified by the commissioner. Eligibility for the budget exception in this paragraph is limited to persons meeting all of the following criteria in the person's most recent assessment:

(1) the person is assessed to need the level of care delivered in a hospital setting as evidenced by the submission of the Department of Human Services form 7096, primary medical provider's documentation of medical monitoring and treatment needs;

(2) the person is assessed to receive a support range budget of E or H; and

(3) the person does not receive community residential services, family residential services, integrated community supports services, or customized living services.

(d) Home care nursing services funded through the budget exception developed under paragraph (c) must be ordered by a physician, physician assistant, or advanced practice registered nurse. If the participant chooses home care nursing, the home care nursing services must be performed by a registered nurse or licensed practical nurse practicing within the registered nurse's or licensed practical nurse's scope of practice as defined under Minnesota Statutes, sections 148.171 to 148.285. If after a person's annual reassessment under Minnesota Statutes, section 256B.0911, any requirements of this paragraph or paragraph (c) are no longer met, the commissioner must terminate the budget exception.

~~(c)~~ (e) The commissioner of human services may seek all federal authority necessary to implement this section.

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

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

Sec. 74. Laws 2021, First Special Session chapter 7, article 13, section 75, subdivision 6, as amended by Laws 2024, chapter 108, article 1, section 28, is amended to read:

Subd. 6. **Online support planning tool.** The commissioner must develop an online support planning and tracking tool for people using disability waiver services that allows access to the total budget available to the person, the services for which they are eligible, and the services they have chosen and used. The commissioner must explore operability options that would facilitate real-time tracking of a person's remaining available budget throughout the service year. The online support planning tool must provide information in an accessible format to support the person's informed choice. The commissioner must seek input from people with disabilities about the online support planning tool prior to its implementation. The commissioner must implement the online support planning and tracking tool no later than January 1, 2027.

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

Sec. 75. **DISABILITY SERVICES TECHNOLOGY AND ADVOCACY EXPANSION GRANT.**

Subdivision 1. **Establishment.** (a) A disability services technology and advocacy expansion grant is established to:

(1) support the expansion of assistive technology and remote support services for people with disabilities; and

(2) strengthen advocacy efforts for individuals with disabilities and the providers who serve individuals with disabilities.

(b) The commissioner of human services must award the grant to an eligible grantee. In awarding the grant, the commissioner must consult with the commissioner of administration's System of Technology to Achieve Results (STAR) Program under Minnesota Statutes, section 16B.055.

Subd. 2. **Eligible grantee.** An eligible grantee must:

(1) be a nonprofit organization with a statewide reach;

(2) have demonstrated knowledge of various forms of assistive technology and remote support for people with disabilities; and

(3) have proven capacity to provide education and training to multiple constituencies.

Subd. 3. **Allowable uses of grant money.** Grant money must be used to:

(1) develop and deliver comprehensive training programs for lead agencies, disability service providers, schools, employment support agencies, and individuals with disabilities and their families to ensure effective use of assistive technology and remote support tools. Training programs must be developed in consultation with the STAR Program to ensure alignment with national assistive technology standards and best practices. Training must address specific challenges faced by individuals with disabilities, such as accessibility, independence, and health monitoring;

(2) provide resources and support to advocacy organizations that work with individuals with disabilities and service providers. Resources and support must be used to promote the use of assistive technology to increase self-determination and community participation;

(3) maintain, distribute, and create accessible resources related to assistive technology and remote support. Resources must be developed in collaboration with the STAR Program to reflect current assistive technology tools and guidance that are tailored to Minnesota's

disability community. Materials must be tailored to address the unique needs of individuals with disabilities and the people and organizations who support individuals with disabilities;

(4) conduct research to explore new and emerging assistive technology solutions that address the evolving needs of individuals with disabilities. The research must emphasize the role of technology in promoting independence, improving quality of life, and ensuring safety; and

(5) conduct outreach initiatives to engage disability communities, service providers, and advocacy groups across Minnesota to promote awareness of assistive technology and remote support services. Outreach initiatives must focus on reaching underserved and rural populations.

Subd. 4. **Evaluation and reporting requirements.** (a) The grant recipient must submit an annual report by June 30 each year to the chairs and ranking minority members of the legislative committees with jurisdiction over disability services. The annual report must include:

(1) the number of individuals with disabilities and service providers who received training during the reporting year;

(2) data on the impact of assistive technology and remote support in improving quality of life, safety, and independence for individuals with disabilities; and

(3) recommendations for further advancing technology-driven disability advocacy efforts based on feedback and research findings.

(b) No later than three months after the grant period has ended, a final evaluation must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over disability services to assess the overall impact on expanding access to assistive technology and remote support, with a focus on lessons learned and future opportunities for Minnesota's disability communities and service providers.

Subd. 5. **Grant period.** The grant period under this section is from July 1, 2025, to June 30, 2030.

Sec. 76. **BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner of human services must increase the consumer-directed community support budgets identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter

256S; and the alternative care program under Minnesota Statutes, section 256B.0913, by 0.13 percent.

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

Sec. 77. **ENHANCED BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

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

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

Sec. 78. **STIPEND PAYMENTS TO SEIU HEALTHCARE MINNESOTA & IOWA BARGAINING UNIT MEMBERS.**

(a) The commissioner of human services shall issue stipend payments to collective bargaining unit members as required by the labor agreement between the state of Minnesota and the Service Employees International Union (SEIU) Healthcare Minnesota & Iowa.

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

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

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

(e) The amount of stipend payments received by SEIU Healthcare Minnesota & Iowa collective bargaining unit members under this section is excluded from income as defined in Minnesota Statutes, sections 290.0693, subdivision 1, paragraph (i), and 290A.03, subdivision 3.

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

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

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

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

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

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

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

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

Sec. 79. **DIRECTION TO COMMISSIONER; COST REPORTING IMPROVEMENT AND DIRECT CARE STAFF REVIEW.**

(a) The commissioner of human services must consult with interested parties and make recommendations to the legislature to clarify provider cost reporting obligations to promote more uniform and meaningful data collection under Minnesota Statutes, section 256B.4914. By February 15, 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance draft legislation required to implement the commissioner's recommendations.

(b) The commissioner of human services must consult with interested parties and, based on the results of the cost reporting completed for calendar year 2026, recommend what, if any, encumbrance of medical assistance reimbursement is appropriate to support direct care staff retention and the provision of quality services under Minnesota Statutes, section 256B.4914. By January 15, 2028, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance draft legislation required to implement the commissioner's recommendations.

Sec. 80. **COMMUNITY FIRST SERVICES AND SUPPORTS REIMBURSEMENT DURING ACUTE CARE HOSPITAL STAYS.**

(a) The commissioner of human services must seek to amend Minnesota's federally approved community first services and supports program, authorized under United States

Code, title 42, sections 1915(i) and 1915(k), to reimburse for delivery of community first services and supports under Minnesota Statutes, sections 256B.85 and 256B.851, during an acute care stay in an acute care hospital setting that does not have the effect of isolating individuals receiving community first services and supports from the broader community of individuals not receiving community first services and supports, as permitted under Code of Federal Regulations, title 42, section 441.530.

(b) Reimbursed services must:

(1) be identified in an individual's person-centered support plan as required under Minnesota Statutes, section 256B.0911;

(2) be provided to meet the needs of the person that are not met through the provision of hospital services;

(3) not substitute services that the hospital is obligated to provide as required under state and federal law; and

(4) be designed to preserve the person's functional abilities during a hospital stay for acute care and to ensure smooth transitions between acute care settings and home and community-based settings.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) 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. 81. **POSITIVE SUPPORTS COMPETENCY PROGRAM.**

(a) The commissioner shall establish a positive supports competency program with the money appropriated for this purpose.

(b) When establishing the positive supports competency program, the commissioner must use a community-partner-driven process to:

(1) define the core activities associated with effective intervention services at the levels of positive support specialist, positive support analyst, and positive support professional;

(2) create tools providers may use to track whether their positive supports specialists, positive support analysts, and positive support professionals are competently performing the core activities associated with effective intervention services;

(3) align existing training systems funded through the Department of Human Services and develop free online modules for competency-based training to prepare positive support

specialists, positive support analysts, and positive support professionals to provide effective intervention services;

(4) assist providers interested in utilizing a competency-based training model to create a career pathway for the positive support analysts and positive support specialists within their organizations by using experienced professionals;

(5) create written guidelines, stories, and examples for providers that will be placed on Department of Human Services websites promoting capacity building; and

(6) disseminate resources and guidance to providers interested in meeting competency-based qualifications for positive supports through existing regional networks of experts, including communities of practice, and develop new avenues for disseminating these resources and guidance, including through implementation of ECHO models.

Sec. 82. **DIRECTION TO COMMISSIONER; INTEGRATED COMMUNITY SUPPORTS CODIFICATION.**

(a) The commissioner of human services must develop draft language to codify in Minnesota Statutes the standards and requirements for integrated community supports as specified in the federally approved brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans.

(b) When developing and drafting the proposed legislative language, the commissioner must consult with interested parties, including the Association of Residential Resources in Minnesota, the Residential Providers Association of Minnesota, the Minnesota Association of County Social Service Administrators, and people with disabilities currently or potentially receiving integrated community supports. The commissioner must ensure that the interested parties with whom the commissioner consults represent a broad spectrum of active and potential providers and service recipients. The commissioner's consultation with interested parties must be transparent and provide the opportunity for meaningful input from active and potential providers and service recipients.

(c) The commissioner must submit the draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2026.

Sec. 83. **DIRECTION TO COMMISSIONER; PROVISIONAL OR TRANSITIONAL APPROVAL OF INTEGRATED COMMUNITY SERVICES SETTINGS.**

(a) The commissioner of human services must develop draft language to improve the process for approving integrated community supports settings, including a process for issuing provisional or transitional licenses to allow applicants to obtain an initial approval to operate prior to securing control of the approved setting. This process must also allow applicants to change the approved setting during the application review period when needed to ensure an available setting.

(b) The commissioner must submit the draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2026.

Sec. 84. **DIRECTION TO COMMISSIONER; GUIDANCE TO COUNTIES.**

Upon receipt of approval from the Centers for Medicare and Medicaid Services, the commissioner of human services shall provide guidance to counties on the administration of the family support program under Minnesota Statutes, section 252.32; the consumer support program under Minnesota Statutes, section 256.476; disability waivers under Minnesota Statutes, sections 256B.092 and 256B.49; and the community first services and supports program under Minnesota Statutes, section 256B.85, to clarify that the cost of adaptive or one-on-one swimming lessons provided to a person younger than 12 years of age whose disability puts the person at a higher risk of drowning according to the Centers for Disease Control Vital Statistics System is an allowable use of money.

Sec. 85. **DIRECTION TO COMMISSIONER; SWIMMING LESSONS COVERED UNDER DISABILITY WAIVERS.**

The commissioner of human services shall include swimming lessons for a participant younger than 12 years of age whose disability puts the participant at a higher risk of drowning as a covered service under the disability waivers, including the consumer-directed community supports option, under Minnesota Statutes, sections 256B.092 and 256B.49.

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. 86. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DEVELOPMENT OF COMPREHENSIVE EIDBI LICENSE.**

(a) By October 1, 2025, the commissioner of human services must convene a working group consisting of staff from the Department of Human Services with policy and clinical expertise related to EIDBI services, and with expertise in licensing standards for other licensed programs and settings, particularly other programs serving children; staff from the Department of Children, Youth, and Families with expertise in the licensing standards for home child care and child care centers; the Early Intensive Developmental and Behavioral Advisory Council; families of individuals receiving EIDBI services; advocates for individuals receiving EIDBI services; and other community partners and interested parties.

(b) The working group must advise the commissioner as the commissioner develops comprehensive EIDBI licensing standards and a plan to transition EIDBI agencies from the provisional license established under Minnesota Statutes, section 245A.142, to a newly established comprehensive EIDBI license. The working group must provide the commissioner with advice on at least the following topics:

(1) basic health and safety standards;

(2) basic physical plant standards;

(3) medication management and other ancillary services that might be provided by EIDBI providers;

(4) privacy and the use of cameras in settings where EIDBI services are being provided;

(5) third-party billing procedures and requirements;

(6) billing standards and policies regarding duplicative, simultaneous, and mid-point billing practices;

(7) measures of clinical effectiveness; and

(8) appropriate restrictions on the commissioner's authority under Minnesota Statutes, section 256B.0949, subdivision 17, to issue exceptions to EIDBI provider qualifications, medical assistance provider enrollment requirements, and EIDBI provider or agency standards or requirements.

(c) By January 1, 2027, the commissioner must propose standards for a nonprovisional, comprehensive EIDBI license or licenses, and submit proposed draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over EIDBI services.

Sec. 87. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; TEMPORARY MORATORIUM ON ENROLLMENT OF NEW EIDBI PROVIDERS.**

Upon federal approval and subject to continued federal approval, beginning July 1, 2025, the commissioner must not enroll new EIDBI agencies to provide EIDBI services under Minnesota Statutes, chapter 256B, unless the agency is licensed as an EIDBI agency under Minnesota Statutes, chapter 245A, but may enroll new locations where EIDBI services are provided by an agency that was enrolled prior to July 1, 2025.

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

Sec. 88. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; INCREASE TO PAYMENTS FOR FAMILY RESIDENTIAL AND LIFE SHARING SERVICES.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner of human services must increase by 51.69 percent payment rates previously established under Minnesota Statutes, section 256B.4914, subdivision 19, for family residential services. Rates for life sharing services must be ten percent higher than the corresponding family residential services rate established under this section.

Sec. 89. **COMMISSIONER OF HUMAN SERVICES; WAIVER CASE MANAGEMENT EVALUATION AND RATE STUDY.**

Subdivision 1. **Reimbursement rate study.** The commissioner of human services must issue a request for proposals to develop and model a proposed reimbursement rate methodology for waiver case management services under Minnesota Statutes, sections 256B.0913, 256B.092, 256B.0922, and 256B.49, and Minnesota Statutes, chapter 256S. The proposed methodology for waiver case management reimbursement rates must be predicated on a methodology that is transparent, culturally responsive, and supportive of lead agency staffing needed to provide high-quality, person-centered, and culturally responsive case management services. The development of the rate methodology must consider costs and workforce pressures that impact the delivery of case management services; costs to provide culturally responsive case management services as described in Minnesota Statutes, section 256B.076, subdivision 3; and compensation required to attract and retain qualified case managers.

Subd. 2. **Evaluation of case management service delivery.** The commissioner must conduct an evaluation of lead agency duties associated with waiver case management; current caseloads; best practices related to caseloads and case mix; required professional

qualifications, experience, and training of case management professionals; and quality assurance measures, and make recommendations to improve the quality, consistency, and timeliness of the provision of waiver case management services.

Subd. 3. **Community engagement.** (a) The commissioner must consult with interested parties from across each region of the state including, but not limited to, lead agencies, contracted waiver case management service providers, culturally responsive providers, individuals receiving services and their families, advocacy organizations, and relevant experts in the development of the request for proposals under subdivision 1.

(b) The commissioner must collaborate with interested parties from across each region of the state including, but not limited to, lead agencies, contracted waiver case management service providers, culturally responsive providers, individuals receiving services and their families, advocacy organizations, and relevant experts in the evaluation of the delivery of waiver case management services.

Subd. 4. **Recommendations and reports.** By December 15, 2025, the commissioner of human services must submit a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance on the initial results of the rate study and service delivery evaluation. By December 15, 2026, the commissioner of human services must submit to the chairs and ranking minority members of committees with jurisdiction over health and human services a report detailing (1) the waiver rate methodology, including all rate components, and modeled rates; and (2) findings and recommendations of the evaluation of case management service delivery. The report must include (1) legislative language necessary to modify existing or implement new rate methodologies and a detailed fiscal analysis of the proposed rate methodology; and (2) legislative language necessary to implement recommendations to improve wavier case management service delivery.

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

Sec. 90. **CHAPTER 245D PROVIDER LICENSING TIMELINESS IMPROVEMENT INITIATIVE.**

(a) The commissioner of human services must conduct a comprehensive business process analysis and redesign of the provider licensing system with a particular focus on Minnesota Statutes, chapter 245D, licensing activities.

(b) The commissioner's business process analysis must include at least the following elements:

(1) a full mapping of the current provider licensing process, including provider inquiry, application intake, documentation requirements, inspections, background checks, approval or denial, and renewal processes;

(2) identification of all bottlenecks, backlogs, batches, redundancies, and inefficiencies;

(3) engagement with providers, people receiving services, lead agencies, and advocates and other stakeholders to gather feedback on process challenges and recommendations for improvement; and

(4) analysis of opportunities to incorporate digital and tech solutions or workflow automation.

(c) When developing a proposal to redesign Minnesota Statutes, chapter 245D, licensing processes to better service individuals and providers, the commissioner must work directly with licensing staff, managers, and leadership and develop revised performance metrics and timelines, including a target average time frame for initial license decisions and renewals with the creation of a dashboard assuring transparency and ongoing accountability.

(d) By January 1, 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services licensing and over long-term services and supports a report that includes:

(1) the findings of the analysis of current Minnesota Statutes, chapter 245D, provider licensing processes;

(2) the proposed redesign of Minnesota Statutes, chapter 245D, provider licensing processes;

(3) an implementation plan of agreed upon improvements with timelines and required resources; and

(4) recommended statutory or regulatory changes, if any, necessary to support implementation.

Sec. 91. **REPEALER.**

Subdivision 1. **Obsolete home and community-based services licensing provisions.** Minnesota Statutes 2024, section 245A.042, subdivisions 2, 3, and 4, are repealed.

Subd. 2. **Direct care provider premiums.** Laws 2023, chapter 59, article 3, section 11, is repealed.

Subd. 3. **Legislative Task Force on Guardianship.** Laws 2024, chapter 127, article 46, section 39, is repealed.

Subd. 4. **Revision of treatment modalities.** Minnesota Statutes 2024, section 256B.0949, subdivision 9, is repealed.

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

ARTICLE 3
LONG-TERM SERVICES AND SUPPORTS REFORM

Section 1. Minnesota Statutes 2024, section 256B.49, is amended by adding a subdivision to read:

Subd. 17a. **Service authorizations and service agreements; generally.** Recipients must be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

Sec. 2. Minnesota Statutes 2024, section 256B.49, is amended by adding a subdivision to read:

Subd. 17b. **Service authorizations and service agreements; community access for disability inclusion waiver services.** (a) For service agreements under the community access for disability inclusion waiver program only, the commissioner must require lead agency supervisors to review and accept all service agreements entered by lead agency staff into the Medicaid management information system (MMIS) prior to the commissioner's approval of the service agreement.

(b) For a service agreement under the community access for disability inclusion waiver with a proposed total authorized amount that exceeds the total authorized amount in the recipient's prior service agreement by more than the value of legislatively enacted rate increases, the commissioner must manually review and manually approve the service agreement in the MMIS. For purposes of this paragraph, "prior service agreement" means the service agreement that was in effect 12 months prior to the start date of the new proposed service agreement.

(c) In a format prescribed by the commissioner, lead agencies must submit the following information for all service agreements subject to the commissioner's approval in paragraph (b):

(1) changes in the number of units authorized;

(2) new services authorized;

(3) changes in the values used to calculate service rates under section 256B.4914, except for automatic adjustments required under section 256B.4914, subdivisions 5 and 5b;

(4) changes in the person's level of need requiring an increase in the amount of services authorized;

(5) documentation detailing why the previous amount of services is not sufficient to meet the person's needs; and

(6) anticipated impact if the total service amount is not increased to the proposed amount.

(d) Except for rate increases required under section 256B.4914, subdivisions 5 and 5b, and rate changes authorized by the 2025 legislature, the commissioner must not approve service agreements under paragraph (b) that are not the result of either a documented change in a person's assessed needs or documented evidence that the previous level of service was insufficient to meet the person's assessed needs.

(e) This subdivision expires upon full implementation of waiver reimagine. The commissioner must inform the revisor of statutes when waiver reimagine is fully implemented.

Sec. 3. Minnesota Statutes 2024, section 256B.49, subdivision 18, is amended to read:

Subd. 18. **Payments.** The commissioner shall reimburse approved vendors from the medical assistance account for the costs of providing home and community-based services to eligible recipients using the invoice processing procedures of the Medicaid management information system (MMIS). ~~Recipients will be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.~~

Sec. 4. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; LONG-TERM SERVICES AND SUPPORTS REFORM WORK GROUP.**

Subdivision 1. **Development of alternative service models for long-term services and supports.** (a) By October 1, 2025, the commissioner of human services must convene a group of department staff and community partners to assist the commissioner in developing alternative service models to provide long-term services and supports to people with limited dependencies, low-acuity assessed needs, or natural supports. The commissioner is encouraged to consider increasing available service models; tailoring available services to meet the needs of the target population; supplementing or subsidizing family caregivers, religious organizations, social clubs, and similar civic and service organizations; exercising

the commissioner's authority under Minnesota Statutes, section 256B.092, subdivision 4a; reexamining the provision of services under Minnesota Statutes, section 245A.03, subdivision 9; reexamining the viability of a demonstration project similar for the target population to the projects authorized under Minnesota Statutes, sections 256B.69, subdivision 23, and 256B.77; modifying licensing and regulator requirements to permit family or other natural supports to live with a person with a disability, behavioral health needs, or an older adult in licensed settings, such as an assisted living facility or senior living setting; and tax credits or other tax incentives to encourage intergenerational living arrangements, accessory dwelling units, or other residential arrangements that permit easier access to natural supports.

(b) By October 1, 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance long-term services and supports a set of proposals that if enacted is estimated to reduce expected general fund expenditures relative to the February 2025 forecast during the biennium beginning July 1, 2027, by at least the amount assumed in subdivision 3, paragraph (a). An estimate of the estimated savings as well as a summary of the expected impact on people served must accompany each proposal.

Subd. 2. **Administration.** (a) The commissioner of human services must provide meeting space and general administrative support to the workgroup.

(b) The commissioner of human services must contract with a third party to provide facilitation services for the workgroup. Use of a third party for this purpose is exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

(c) The commissioner of human services may contract with a third party or parties to provide policy research and analysis, data analysis, and administrative support related to drafting the action plan and supporting materials. Use of a third party for these purposes is exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

Subd. 3. **Savings determination.** (a) When preparing the forecast for state revenues and expenditures under Minnesota Statutes, section 16A.103, the commissioner of management and budget must assume a reduction of human services spending of $135,000,000 relative to the February 2025 forecast for the biennium beginning July 1, 2027, until the end of the legislative session that enacts a budget for the Department of Human Services for the biennium beginning July 1, 2027.

(b) Upon enactment of a budget for the Department of Human Services for the biennium beginning July 1, 2027, the legislature must identify enacted provisions that were

recommended by or based on the action plan submitted by the commissioner of human services under subdivision 1.

(c) To the extent the net savings attributable to the provisions identified by the legislature under paragraph (b) for the biennium beginning July 1, 2027, are less than the assumed savings in paragraph (a), the commissioner of human services must implement the contingent rate reductions described in subdivision 4.

Subd. 4. **Contingent rate reductions.** If upon enactment of a budget for the Department of Human Services for the biennium beginning July 1, 2027, the net savings for the biennium beginning July 1, 2027, attributable to the provisions identified by the legislature under subdivision 3, paragraph (b), are less than the assumed savings in subdivision 3, paragraph (a), notwithstanding Minnesota Statutes, section 256B.4914, the commissioner of human services must adjust the competitive workforce factors under Minnesota Statutes, section 256B.4914, subdivisions 6 to 9, to a value that will produce by June 30, 2029, a net reduction in expected general fund expenditures relative to the February 2025 forecast equal to the difference between the savings attributable to the provisions identified in subdivision 3, paragraph (b), and the assumed savings in subdivision 3, paragraph (a).

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

Sec. 5. **DIRECTION TO THE COMMISSIONERS OF HUMAN SERVICES AND MANAGEMENT AND BUDGET; COST SAVING REFORMS WORKING GROUP.**

Subdivision 1. **Identifying cost saving reforms.** (a) By October 1, 2025, the commissioner of human services must convene a group of department staff and community partners to assist the commissioner in identifying cost saving reforms to licensing requirements, service standards, provider qualifications, provider duties and responsibilities, lead agency duties and responsibilities, eligibility, covered services, service authorizations, service limits, service rate calculations, rate enhancements and add-ons, rate exceptions, rate limits, budget limits, or any other cost saving reforms to medical assistance long-term services and supports and other programs serving people with disabilities, people with behavioral health needs, or older adults.

(b) By October 1, 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance long-term services and supports an action plan that if enacted is estimated to reduce expected general fund expenditures relative to the February 2025 forecast during the biennium beginning July 1, 2027, by at least the amount assumed in subdivision 3, paragraph (a). Each strategy

included in the action plan must include an estimate of the estimated savings as well as a summary of the expected impact on people served.

Subd. 2. **Administration.** (a) The commissioner of human services must provide meeting space and general administrative support to the workgroup.

(b) The commissioner of human services must contract with a third party to provide facilitation services for the workgroup. Use of a third party for this purpose is exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

(c) The commissioner of human services may contract with a third party or parties to provide policy research and analysis, data analysis, and administrative support related to drafting the action plan and supporting materials. Use of a third party for these purposes is exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

Subd. 3. **Savings determination.** (a) When preparing the forecast for state revenues and expenditures under Minnesota Statutes, section 16A.103, the commissioner of management and budget must assume a reduction of human services spending of $150,000,000 relative to the February 2025 forecast for the biennium beginning July 1, 2027, until the end of the legislative session that enacts a budget for the Department of Human Services for the biennium beginning July 1, 2027.

(b) Upon enactment of a budget for the Department of Human Services for the biennium beginning July 1, 2027, the legislature must identify enacted provisions that were recommended by or based on the action plan submitted by the commissioner of human services under subdivision 1.

(c) To the extent the net savings attributable to the provisions identified by the legislature under paragraph (b) for the biennium beginning July 1, 2027, are less than the assumed savings in paragraph (a), the commissioner of human services must implement the contingent rate reductions described in subdivision 4.

Subd. 4. **Contingent rate reductions.** If upon enactment of a budget for the Department of Human Services for the biennium beginning July 1, 2027, the net savings for the biennium beginning July 1, 2027, attributable to the provisions identified by the legislature under subdivision 3, paragraph (b), are less than the assumed savings in subdivision 3, paragraph (a), notwithstanding Minnesota Statutes, section 256B.4914, the commissioner of human services must adjust the competitive workforce factors under Minnesota Statutes, section 256B.4914, subdivisions 6 to 9, to a value that will produce by June 30, 2029, a net reduction in expected general fund expenditures relative to the February 2025 forecast equal to the

difference between the savings attributable to the provisions identified in subdivision 3, paragraph (b), and the assumed savings in subdivision 3, paragraph (a).

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

Sec. 6. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; OPTIONAL CONSULTATION SERVICES.**

The commissioner of human services must consider submitting a medical assistance state plan amendment to permit consultation services that are currently required under the community first services and supports program to be an optional service for individuals receiving waiver case management services under Minnesota Statutes, sections 256B.0913, 256B.092, 256B.0922, and 256B.49, or Minnesota Statutes, chapter 256S.

Sec. 7. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; LONG-TERM CARE CONSULTATION SERVICES PAYMENT REFORM.**

Subdivision 1. **Development of alternative payment methodology for long-term care consultation services.** (a) The commissioner of human services must develop a proposal for a long-term care consultation services payment methodology that does not rely on a time study to determine reimbursement to the counties for providing long-term care consultation services under Minnesota Statutes, section 256B.0911. The new reimbursement methodology must be a methodology that:

(1) results in a flat reimbursement amount per long-term care consultation assessment under Minnesota Statutes, section 256B.0911;

(2) reduces expected general fund expenditures relative to the February 2025 forecast during the biennium beginning July 1, 2027, by at least the amount assumed in subdivision 2, paragraph (a);

(3) preserves the commissioner's ability to allocate to medical assistance costs incurred by counties for providing long-term care consultation services; and

(4) does not jeopardize the commissioner's ability to allocate other local administrative costs to medical assistance or other federal programs.

(b) By October 1, 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance long-term services and supports the proposal developed under paragraph (a) and any draft legislation required to implement the proposal.

Subd. 2. **Savings determination.** (a) When preparing the forecast for state revenues and expenditures under Minnesota Statutes, section 16A.103, the commissioner of management and budget must assume a reduction of human services spending of $18,000,000 relative to the February 2025 forecast for the biennium beginning July 1, 2027, until the end of the legislative session that enacts a budget for the Department of Human Services for the biennium beginning July 1, 2027.

(b) Upon enactment of a budget for the Department of Human Services for the biennium beginning July 1, 2027, the legislature must identify enacted provisions that were recommended by or based on the proposal submitted by the commissioner of human services under subdivision 1.

(c) To the extent the net savings attributable to the provisions identified by the legislature under paragraph (b) for the biennium beginning July 1, 2027, are less than the assumed savings in paragraph (a), the commissioner of human services shall implement the contingent reductions in reimbursement to counties described in subdivision 4.

Subd. 3. **Contingent reimbursement reductions.** If upon enactment of a budget for the Department of Human Services for the biennium beginning July 1, 2027, the net savings for the biennium beginning July 1, 2027, attributable to the provisions identified by the legislature under subdivision 2, paragraph (b), are less than the assumed savings in subdivision 2, paragraph (a), notwithstanding Minnesota Statutes, section 256B.0911, subdivision 33, the commissioner of human services must reduce the percentage of the nonfederal share for the provision of long-term care consultation services the state pays to the counties as reimbursement to a value that will produce by June 30, 2029, a net reduction in expected general fund expenditures relative to the February 2025 forecast equal to the difference between the savings attributable to the provisions identified in subdivision 2, paragraph (b), and the assumed savings in subdivision 2, paragraph (a).

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

Sec. 8. **DIRECTIONS TO THE COMMISSIONERS OF HUMAN SERVICES AND MANAGEMENT AND BUDGET; ADDITIONAL OFFSETS TO CONTINGENT REIMBURSEMENT REDUCTIONS.**

(a) When preparing the forecast for state revenues and expenditures under Minnesota Statutes, section 16A.103, the commissioner of management and budget, in consultation with the commissioner of human services, must estimate the net reduction in estimated spending for the biennium beginning July 1, 2027, attributable to the amendments in sections

1 to 3 and 6 of this article that exceed the general fund reductions included in this act for these sections of this article.

(b) The commissioner of management and budget must reduce the assumed reductions in human services spending required under section 7, subdivision 2, paragraph (a), of this article by the amount identified in paragraph (a).

(c) If the amount identified in paragraph (a) exceeds the assumed reductions required under section 7, subdivision 2, paragraph (a), of this article, notwithstanding Minnesota Statutes, section 256B.0911, subdivision 33, the commissioner of human services must increase the percentage of the nonfederal share for the provision of long-term care consultation services the state pays to the counties as reimbursement to a value that will produce, by June 30, 2029, a net zero change in expected general fund expenditures relative to the February 2025 forecast for these services.

ARTICLE 4
SUBSTANCE USE DISORDER TREATMENT

Section 1. Minnesota Statutes 2024, section 245G.01, subdivision 13b, is amended to read:

Subd. 13b. **Guest speaker.** (a) "Guest speaker" means an individual who is not an alcohol and drug counselor qualified according to section 245G.11, subdivision 5; is not qualified according to the commissioner's list of professionals under section 245G.07, subdivision 3; and who works under the direct observation of an alcohol and drug counselor to present to clients on topics in which the guest speaker has expertise and that the license holder has determined to be beneficial to a client's recovery.

(b) Tribally licensed programs have autonomy to identify the qualifications of their guest speakers.

EFFECTIVE DATE. This section is effective July 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. 2. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 13d. **Individual counseling.** "Individual counseling" means professionally led psychotherapeutic treatment for substance use disorders that is delivered in a one-to-one setting or in a setting with the client and the client's family and other natural supports.

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

Sec. 3. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 20f. **Psychoeducation.** "Psychoeducation" means the services described in section 245G.07, subdivision 1a, clause (2).

EFFECTIVE DATE. This section is effective July 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. 4. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 20g. **Psychosocial treatment services.** "Psychosocial treatment services" means the services described in section 245G.07, subdivision 1a.

EFFECTIVE DATE. This section is effective July 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. 5. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 20h. **Recovery support services.** "Recovery support services" means the services described in section 245G.07, subdivision 2a, paragraph (b), clause (1).

EFFECTIVE DATE. This section is effective July 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. 6. Minnesota Statutes 2024, section 245G.01, is amended by adding a subdivision to read:

Subd. 26a. **Treatment coordination.** "Treatment coordination" means the services described in section 245G.07, subdivision 1b.

EFFECTIVE DATE. This section is effective July 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. 7. Minnesota Statutes 2024, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 1a, and 4; 245G.07, ~~subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7)~~ subdivision 1a, clause (2); and 245G.17.

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

Sec. 8. Minnesota Statutes 2024, 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 five calendar days from the day of service initiation for a residential program or 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.

(b) A comprehensive assessment must be administered by:

(1) an alcohol and drug counselor;

(2) a mental health professional who meets the qualifications under section 245I.04, subdivision 2, practices within the scope of their professional licensure, and has training in addiction, co-occurring disorders, and substance use disorder diagnosis and treatment according to the requirements in section 245G.13, subdivision 2, paragraph (f);

(3) a clinical trainee who meets the qualifications under section 245I.04, subdivision 6, practicing under the supervision of a mental health professional who meets the requirements of clause (2); or

(4) an advanced practice registered nurse as defined in section 148.171, subdivision 3, who practices within the scope of their professional licensure and has training in addiction, co-occurring disorders, and substance use disorder diagnosis and treatment according to the requirements in section 245G.13, subdivision 2, paragraph (f).

(c) 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~~ a staff member qualified under paragraph (b) 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. ~~An alcohol and drug counselor~~ A staff member qualified under paragraph (b) must sign and date the comprehensive assessment review and update.

Sec. 9. Minnesota Statutes 2024, section 245G.07, subdivision 1, is amended to read:

Subdivision 1. **Treatment service.** (a) A licensed ~~residential~~ treatment program must offer the treatment services in ~~clauses (1) to (5)~~ subdivisions 1a and 1b and may offer the treatment services in subdivision 2 to each client, unless clinically inappropriate and the justifying clinical rationale is documented. ~~A nonresidential~~ The treatment program must ~~offer all treatment services in clauses (1) to (5) and~~ document in the individual treatment plan the specific services for which a client has an assessed need and the plan to provide the services~~:~~.

~~(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder;~~

~~(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis;~~

~~(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;~~

~~(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan; and~~

~~(5) treatment coordination provided one-to-one by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Treatment coordination services include:~~

~~(i) assistance in coordination with significant others to help in the treatment planning process whenever possible;~~

~~(ii) assistance in coordination with and follow up for medical services as identified in the treatment plan;~~

~~(iii) facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;~~

~~(iv) facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;~~

~~(v) assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;~~

~~(vi) life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and~~

~~(vii) documentation of the provision of treatment coordination services in the client's file.~~

(b) A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client.

(c) A supportive service alone does not constitute a treatment service. Supportive services include:

(1) milieu management or supervising or monitoring clients without also providing a treatment service identified in subdivision 1a, 1b, or 2a;

(2) transporting clients;

(3) waiting with clients for appointments at social service agencies, court hearings, and similar activities; and

(4) collecting urinalysis samples.

(d) A treatment service provided in a group setting must be provided in a cohesive manner and setting that allows every client receiving the service to interact and receive the same service at the same time.

EFFECTIVE DATE. This section is effective July 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. 10. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision to read:

Subd. 1a. **Psychosocial treatment service.** Psychosocial treatment services must be provided according to the hours identified in section 254B.19 for the ASAM level of care provided to the client. A license holder must provide the following psychosocial treatment services as a part of the client's individual treatment:

(1) counseling services that provide a client with professional assistance in managing substance use disorder and co-occurring conditions, either individually or in a group setting. Counseling must:

(i) use evidence-based techniques to help a client modify behavior, overcome obstacles, and achieve and sustain recovery through techniques such as active listening, guidance, discussion, feedback, and clarification;

(ii) help the client to identify and address needs related to substance use, develop strategies to avoid harmful substance use, and establish a lifestyle free of the harmful effects of substance use disorder; and

(iii) work to improve well-being and mental health, resolve or mitigate symptomatic behaviors, beliefs, compulsions, thoughts, and emotions, and enhance relationships and social skills, while addressing client-centered psychological and emotional needs; and

(2) psychoeducation services to provide a client with information about substance use and co-occurring conditions, either individually or in a group setting. Psychoeducation includes structured presentations, interactive discussions, and practical exercises to help clients understand and manage their conditions effectively. Topics include but are not limited to:

(i) the causes of substance use disorder and co-occurring disorders;

(ii) behavioral techniques that help a client change behaviors, thoughts, and feelings;

(iii) the importance of maintaining mental health, including understanding symptoms of mental illness;

(iv) medications for addiction and psychiatric disorders and the importance of medication adherence;

(v) the importance of maintaining physical health, health-related risk factors associated with substance use disorder, and specific health education on tuberculosis, HIV, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis; and

(vi) harm-reduction strategies.

EFFECTIVE DATE. This section is effective July 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. 11. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision to read:

Subd. 1b. **Treatment coordination.** (a) Treatment coordination must be provided to a single client by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Treatment coordination services include:

(1) coordinating directly with others involved in the client's treatment and recovery, including the referral source, family or natural supports, social services agencies, and external care providers;

(2) providing clients with training and facilitating connections to community resources that support recovery;

(3) assisting clients in obtaining necessary resources and services such as financial assistance, housing, food, clothing, medical care, education, harm reduction services, vocational support, and recreational services that promote recovery;

(4) helping clients connect and engage with self-help support groups and expand social support networks with family, friends, and organizations; and

(5) assisting clients in transitioning between levels of care, including providing direct connections to ensure continuity of care.

(b) Treatment coordination does not include coordinating services or communicating with staff members within the licensed program.

(c) Treatment coordination may be provided in a setting with the individual client and others involved in the client's treatment and recovery.

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

Sec. 12. Minnesota Statutes 2024, section 245G.07, is amended by adding a subdivision to read:

Subd. 2a. **Ancillary treatment service.** (a) A license holder may provide ancillary services in addition to the hours of psychosocial treatment services identified in section 254B.19 for the ASAM level of care provided to the client.

(b) A license holder may provide the following ancillary treatment services as a part of the client's individual treatment:

(1) recovery support services provided individually or in a group setting, that include:

(i) supporting clients in restoring daily living skills, such as health and health care navigation and self-care to enhance personal well-being;

(ii) providing resources and assistance to help clients restore life skills, including effective parenting, financial management, pro-social behavior, education, employment, and nutrition;

(iii) assisting clients in restoring daily functioning and routines affected by substance use and supporting them in developing skills for successful community integration; and

(iv) helping clients respond to or avoid triggers that threaten their community stability, assisting the client in identifying potential crises and developing a plan to address them, and providing support to restore the client's stability and functioning; and

(2) peer recovery support services provided according to sections 254B.05, subdivision 5, and 254B.052.

EFFECTIVE DATE. This section is effective July 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. 13. Minnesota Statutes 2024, section 245G.07, subdivision 3, is amended to read:

Subd. 3. ~~**Counselors**~~ **Treatment service providers.** (a) All treatment services~~, except peer recovery support services and treatment coordination,~~ must be provided by an ~~alcohol and drug counselor qualified according to section 245G.11, subdivision 5, unless the~~ individual ~~providing the service is~~ specifically qualified according to the accepted credential required to provide the service. ~~The commissioner shall maintain a current list of professionals qualified to provide treatment services.~~

(b) Psychosocial treatment services must be provided by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5, unless the individual providing the service is specifically qualified according to the accepted credential required to provide the service. The commissioner shall maintain a current list of professionals qualified to provide psychosocial treatment services.

(c) Treatment coordination must be provided by a treatment coordinator qualified according to section 245G.11, subdivision 7.

(d) Recovery support services must be provided by a behavioral health practitioner qualified according to section 245G.11, subdivision 12.

(e) Peer recovery support services must be provided by a recovery peer qualified according to section 245I.04, subdivision 18.

EFFECTIVE DATE. This section is effective July 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. 14. Minnesota Statutes 2024, section 245G.07, subdivision 4, is amended to read:

Subd. 4. **Location of service provision.** (a) The license holder must provide all treatment services a client receives at one of the license holder's substance use disorder treatment licensed locations or at a location allowed under paragraphs (b) to (f). If the services are provided at the locations in paragraphs (b) to (d), the license holder must document in the client record the location services were provided.

(b) The license holder may provide nonresidential individual treatment services at a client's home or place of residence.

(c) If the license holder provides treatment services by telehealth, the services must be provided according to this paragraph:

(1) the license holder must maintain a licensed physical location in Minnesota where the license holder must offer all treatment services in subdivision ~~1, paragraph (a), clauses (1) to (4),~~ 1a physically in-person to each client;

(2) the license holder must meet all requirements for the provision of telehealth in sections 254B.05, subdivision 5, paragraph (f), and 256B.0625, subdivision 3b. The license holder must document all items in section 256B.0625, subdivision 3b, paragraph (c), for each client receiving services by telehealth, regardless of payment type or whether the client is a medical assistance enrollee;

(3) the license holder may provide treatment services by telehealth to clients individually;

(4) the license holder may provide treatment services by telehealth to a group of clients that are each in a separate physical location;

(5) the license holder must not provide treatment services remotely by telehealth to a group of clients meeting together in person, unless permitted under clause (7);

(6) clients and staff may join an in-person group by telehealth if a staff member qualified to provide the treatment service is physically present with the group of clients meeting together in person; and

(7) the qualified professional providing a residential group treatment service by telehealth must be physically present on-site at the licensed residential location while the service is being provided. If weather conditions or short-term illness prohibit a qualified professional from traveling to the residential program and another qualified professional is not available to provide the service, a qualified professional may provide a residential group treatment service by telehealth from a location away from the licensed residential location. In such circumstances, the license holder must ensure that a qualified professional does not provide a residential group treatment service by telehealth from a location away from the licensed residential location for more than one day at a time, must ensure that a staff person who qualifies as a paraprofessional is physically present with the group of clients, and must document the reason for providing the remote telehealth service in the records of clients receiving the service. The license holder must document the dates that residential group treatment services were provided by telehealth from a location away from the licensed residential location in a central log and must provide the log to the commissioner upon request.

(d) The license holder may provide the ~~additional~~ ancillary treatment services under subdivision ~~2, clauses (2) to (6) and (8),~~ 2a away from the licensed location at a suitable location appropriate to the treatment service.

(e) Upon written approval from the commissioner for each satellite location, the license holder may provide nonresidential treatment services at satellite locations that are in a school, jail, or nursing home. A satellite location may only provide services to students of the school, inmates of the jail, or residents of the nursing home. Schools, jails, and nursing homes are exempt from the licensing requirements in section 245A.04, subdivision 2a, to document compliance with building codes, fire and safety codes, health rules, and zoning ordinances.

(f) The commissioner may approve other suitable locations as satellite locations for nonresidential treatment services. The commissioner may require satellite locations under this paragraph to meet all applicable licensing requirements. The license holder may not have more than two satellite locations per license under this paragraph.

(g) The license holder must provide the commissioner access to all files, documentation, staff persons, and any other information the commissioner requires at the main licensed location for all clients served at any location under paragraphs (b) to (f).

(h) Notwithstanding sections 245A.65, subdivision 2, and 626.557, subdivision 14, a program abuse prevention plan is not required for satellite or other locations under paragraphs (b) to (e). An individual abuse prevention plan is still required for any client that is a vulnerable adult as defined in section 626.5572, subdivision 21.

EFFECTIVE DATE. This section is effective July 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. 15. Minnesota Statutes 2024, section 245G.11, subdivision 6, is amended to read:

Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights, according to section 148F.165, and staff member responsibilities. A paraprofessional may not make decisions to admit, transfer, or discharge a client but may perform tasks related to intake and orientation. A paraprofessional may be the responsible ~~for the delivery of treatment service~~ staff member according to section 245G.10, subdivision 3. A paraprofessional must not provide a treatment service unless qualified to do so according to section 245G.07, subdivision 3.

Sec. 16. Minnesota Statutes 2024, section 245G.11, is amended by adding a subdivision to read:

Subd. 12. **Behavioral health practitioners.** (a) A behavioral health practitioner must meet the mental health practitioner qualifications in section 245I.04, subdivision 4.

(b) A behavioral health practitioner working within a substance use disorder treatment program licensed under this chapter has the following scope of practice:

(1) a behavioral health practitioner may provide clients with recovery support services, as defined in section 245G.07, subdivision 2a, paragraph (b), clause (1); and

(2) a behavioral health practitioner must not provide treatment supervision to other staff persons.

(c) A behavioral health practitioner working within a substance use disorder treatment program licensed under this chapter must receive at least one hour of supervision per month on individual service delivery from an alcohol and drug counselor or a mental health professional who has substance use treatment and assessments within the scope of their practice.

EFFECTIVE DATE. This section is effective July 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. 17. Minnesota Statutes 2024, section 245G.22, subdivision 11, is amended to read:

Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system. If the person seeking admission cannot be admitted within 14 days of the date of application, each person seeking admission must be placed on the waiting list, unless the person seeking admission is assessed by the program and found ineligible for admission according to this chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12 (e), and title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each person seeking treatment while awaiting admission. A person seeking admission on a waiting list who receives no services under section 245G.07, subdivision ~~1~~ 1a or 1b, must not be considered a client as defined in section 245G.01, subdivision 9.

EFFECTIVE DATE. This section is effective July 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. 18. Minnesota Statutes 2024, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must offer at least ~~50 consecutive minutes~~ four units of individual or group therapy treatment services as defined in section 245G.07, subdivision ~~1, paragraph (a)~~ 1a, clause (1), per week, for the first ten weeks following the day of service initiation, and at least ~~50 consecutive minutes~~ one unit per month thereafter. ~~As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record.~~ The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

EFFECTIVE DATE. This section is effective July 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. 19. Minnesota Statutes 2024, section 254B.01, subdivision 10, is amended to read:

Subd. 10. **~~Skilled~~ Psychosocial treatment services.** "~~Skilled~~ Psychosocial treatment services" includes the treatment services described in section 245G.07, ~~subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled~~ subdivision 1a. Psychosocial treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3, paragraph (b).

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

Sec. 20. Minnesota Statutes 2024, section 254B.04, subdivision 1a, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in

need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (9).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 142G;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to ~~9505.0150~~ 9505.140;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to ~~9500.1318~~ 9500.1272; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.05, subdivision 4.

(i) Persons enrolled in MinnesotaCare are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section 256B.0622.

(j) A person is eligible for one 60-consecutive-calendar-day period per year. A person may submit a request for additional eligibility to the commissioner. A person denied additional eligibility under this paragraph may request a state agency hearing under section 256.045.

EFFECTIVE DATE. This section is effective July 1, 2026, except the amendments to paragraph (d) are effective July 1, 2025.

Sec. 21. Minnesota Statutes 2024, section 254B.05, subdivision 1, is amended to read:

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

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment provided according to section 254A.19, subdivision 3, and treatment services provided according to sections 245G.06 and 245G.07, ~~subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).~~ subdivisions 1, 1a, and 1b.

(c) A county is an eligible vendor for a comprehensive assessment when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 254A.19, subdivision 3. A county is an eligible vendor of ~~care~~ treatment coordination services when provided by an individual

who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision ~~1, paragraph (a), clause (5)~~ 1b. A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8, and according to section 254B.052.

(d) A recovery community organization that meets the requirements of clauses (1) to (14) and meets certification or accreditation requirements of the Alliance for Recovery Centered Organizations, the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification or accreditation on the status of the application within 45 days of receipt. If the approved statewide recovery organization denies an application, it must provide a written explanation for the denial to the recovery community organization. Eligible vendors under this paragraph must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be free from conflicting self-interests, and be autonomous in decision-making, program development, peer recovery support services provided, and advocacy efforts for the purpose of supporting the recovery community organization's mission;

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

(3) have a mission statement and conduct corresponding activities indicating that the organization's primary purpose is to support recovery from substance use disorder;

(4) demonstrate ongoing community engagement with the identified primary region and population served by the organization, including individuals in recovery and their families, friends, and recovery allies;

(5) be accountable to the recovery community through documented priority-setting and participatory decision-making processes that promote the engagement of, and consultation with, people in recovery and their families, friends, and recovery allies;

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

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

(8) maintain organizational practices to meet the needs of Black, Indigenous, and people of color communities, LGBTQ+ communities, and other underrepresented or marginalized communities. Organizational practices may include board and staff training, service offerings, advocacy efforts, and culturally informed outreach and services;

(9) use recovery-friendly language in all media and written materials that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma;

(10) establish and maintain a publicly available recovery community organization code of ethics and grievance policy and procedures;

(11) not classify or treat any recovery peer hired on or after July 1, 2024, as an independent contractor;

(12) not classify or treat any recovery peer as an independent contractor on or after January 1, 2025;

(13) provide an orientation for recovery peers that includes an overview of the consumer advocacy services provided by the Ombudsman for Mental Health and Developmental Disabilities and other relevant advocacy services; and

(14) provide notice to peer recovery support services participants that includes the following statement: "If you have a complaint about the provider or the person providing your peer recovery support services, you may contact the Minnesota Alliance of Recovery Community Organizations. You may also contact the Office of Ombudsman for Mental Health and Developmental Disabilities." The statement must also include:

(i) the telephone number, website address, email address, and mailing address of the Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(ii) the recovery community organization's name, address, email, telephone number, and name or title of the person at the recovery community organization to whom problems or complaints may be directed; and

(iii) a statement that the recovery community organization will not retaliate against a peer recovery support services participant because of a complaint.

(e) A recovery community organization approved by the commissioner before June 30, 2023, must have begun the application process as required by an approved certifying or accrediting entity and have begun the process to meet the requirements under paragraph (d) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(f) A recovery community organization that is aggrieved by an accreditation, certification, or membership determination and believes it meets the requirements under paragraph (d) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (d), the recovery community organization is an eligible vendor of peer recovery support services.

(g) All recovery community organizations must be certified or accredited by an entity listed in paragraph (d) by June 30, 2025.

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

(i) Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed according to section 254A.19, subdivision 3, and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

(j) Any complaints about a recovery community organization or peer recovery support services may be made to and reviewed or investigated by the ombudsperson for behavioral health and developmental disabilities under sections 245.91 and 245.94.

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

Sec. 22. Minnesota Statutes 2024, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) Subject to the requirements of subdivision 6, the commissioner shall establish rates for the following substance use disorder treatment services ~~and service enhancements~~ funded under this chapter~~.~~:

~~(b) Eligible substance use disorder treatment services include:~~

(1) those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to the following ASAM levels of care:

(i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1);

(ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2);

(iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);

(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4);

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5)~~. The commissioner shall use the base payment rate of $79.84 per day for services provided under this item~~;

(vi) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled treatment services each week~~. The commissioner shall use the base payment rate of $166.13 per day for services provided under this item~~;

(vii) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6)~~. The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item~~; and

(viii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7)~~. The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item~~;

(2) comprehensive assessments provided according to section 254A.19, subdivision 3;

(3) treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

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

(6) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to 144.56;

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

(8) medium-intensity residential treatment services that provide 15 hours of skilled treatment services each week and are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license;

(9) 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;

(10) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(11) room and board facilities that meet the requirements of subdivision 1a.

~~(c)~~ (b) The commissioner shall establish higher rates for programs that meet the requirements of paragraph ~~(b)~~ (a) and ~~one of the following additional requirements:~~ the requirements of one clause in this paragraph.

(1) Programs that serve parents with their children are eligible for an enhanced payment rate if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

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

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

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

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

In order to be eligible for a higher rate under this clause, 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.

(2) Culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a~~;~~ are eligible for an enhanced payment rate.

(3) Disability responsive programs as defined in section 254B.01, subdivision 4b~~;~~ are eligible for an enhanced payment rate.

(4) Programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week are eligible for an enhanced payment rate 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 are eligible for an enhanced payment rate if:

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

(ii) the program employs a mental health professional as defined in section 245I.04, subdivision 2;

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

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

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

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

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

~~(e)~~ Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in ~~paragraph (c), clause (5),~~ items (i) to (iv).

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

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

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

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

~~(l)~~ (i) Eligible vendors of peer recovery support services must:

(1) submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity of peer recovery

support services for entities billing for peer recovery support services individually and not receiving a daily rate; and

(2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.

~~(m)~~ (j) Peer recovery support services not provided in accordance with section 254B.052 are subject to monetary recovery under section 256B.064 as money improperly paid.

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

Sec. 23. Minnesota Statutes 2024, section 254B.05, is amended by adding a subdivision to read:

Subd. 6. **Rate adjustments.** (a) Effective for services rendered on or after January 1, 2026, the commissioner must implement the following base payment rates for substance use disorder treatment services under subdivision 5, paragraph (a):

(1) for low-intensity residential, 100 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18;

(2) for high-intensity residential services, the rates in effect on December 31, 2025; and

(3) for all other services not included in clause (1) or (2), 55 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(b) Effective January 1, 2028, and annually thereafter, the commissioner of human services must adjust the payment rates under paragraph (a) according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

Sec. 24. Minnesota Statutes 2024, section 254B.06, is amended by adding a subdivision to read:

Subd. 5. **Prohibition of duplicative claim submission.** (a) For time-based claims, submissions must follow the guidelines in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System and the American Medical Association's Current Procedural Terminology to determine the appropriate units of time to report.

(b) More than half the duration of a time-based code must be spent performing the service to be eligible under this section. Any provision of service during the remaining balance of

the unit of time is not eligible for any other claims submission and would be considered a duplicative claim submission.

(c) A provider may only round up to the next whole number of service units on a submitted claim when more than one and one-half times the defined value of the code has occurred and no additional time increment code exists.

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

Sec. 25. Minnesota Statutes 2024, section 254B.09, subdivision 2, is amended to read:

Subd. 2. **American Indian agreements.** The commissioner may enter into agreements with federally recognized Tribal units to pay for substance use disorder treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements must clarify how the governing body of the Tribal unit fulfills ~~local agency~~ the Tribal unit's responsibilities regarding the form and manner of invoicing.

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

Sec. 26. Minnesota Statutes 2024, section 254B.19, subdivision 1, is amended to read:

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

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

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

(3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours per week of ~~skilled~~ psychosocial treatment services and adolescents must receive six or more hours per week. Vendors must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. ~~Peer recovery~~ Ancillary services and treatment

coordination may be provided beyond the hourly ~~skilled~~ psychosocial treatment service hours allowable per week. If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

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

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

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

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

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

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

(b) Notwithstanding the minimum daily ~~skilled~~ psychosocial treatment service requirements under paragraph (a), clauses (6) and (7), ASAM level 3.3 and 3.5 vendors must provide each client at least 30 hours of treatment services per week for the period between January 1, 2024, through June 30, 2024.

EFFECTIVE DATE. This section is effective July 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. 27. Minnesota Statutes 2024, 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 ~~(n)~~ (m), 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.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from June 30, 2025, whichever is earlier.

Sec. 28. Minnesota Statutes 2024, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from registration and license fee account.** (a) The appropriations in paragraphs (b) to ~~(n)~~ (m) 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) $400,000 is appropriated to the commissioner of human services for competitive grants for opioid-focused Project ECHO programs.

(f) $277,000 in fiscal year 2024 and $321,000 each year thereafter is appropriated to the commissioner of human services to administer the funding distribution and reporting requirements in paragraph ~~(o)~~ (n).

~~(g) $3,000,000 in fiscal year 2025 and $3,000,000 each year thereafter is appropriated to the commissioner of human services for safe recovery sites start-up and capacity building grants under section 254B.18.~~

~~(h)~~ (g) $395,000 in fiscal year 2024 and $415,000 each year thereafter is appropriated to the commissioner of human services for the opioid overdose surge alert system under section 245.891.

~~(i)~~ (h) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

~~(j)~~ (i) $261,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph ~~(n)~~ (m).

~~(k)~~ (j) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

~~(l)~~ (k) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

~~(m)~~ (l) After the appropriations in paragraphs (b) to ~~(l)~~ (k) are made, 50 percent of the remaining amount is appropriated to the commissioner of children, youth, and families for distribution to county social service agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide prevention and child protection services to children and families who are affected by addiction. The commissioner

shall distribute this money proportionally to county social service agencies and Tribal social service agency initiative projects through a formula based on intake data from the previous three calendar years related to substance use and out-of-home placement episodes where parental drug abuse is a reason for the out-of-home placement. County social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide prevention and child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

~~(n)~~ (m) After the appropriations in paragraphs (b) to ~~(m)~~ (l) are made, the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

~~(o)~~ (n) Beginning in fiscal year 2022 and each year thereafter, funds for county social service agencies and Tribal social service agency initiative projects under paragraph ~~(m)~~ (l) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph ~~(n)~~ (m) may be distributed on a calendar year basis.

~~(p)~~ (o) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs (c), (d), (e), ~~(g)~~ (h), ~~(m)~~ (l), and ~~(n)~~ (m) are available for three years after the funds are appropriated.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from June 30, 2025, whichever is earlier.

Sec. 29. Minnesota Statutes 2024, 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 ~~(l)~~ (k), 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 ~~(m)~~ (l), is appropriated from the settlement account to the commissioner of children, youth, and families 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 ~~(m)~~ (l), 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, subdivision 3, funds appropriated in paragraphs (d) and (e) are available for three years after the funds are appropriated.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from June 30, 2025, whichever is earlier.

Sec. 30. Minnesota Statutes 2024, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

(b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical

assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735, subdivision 3, shall be established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services. For CCBHCs certified after September 31, 2020, and before January 1, 2021, the commissioner shall rebase rates according to this clause for services provided on or after January 1, 2024;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments

for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC certified under section 245.735 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision ~~2~~ 2a, paragraph (b), clause ~~(8)~~ (2).

EFFECTIVE DATE. This section is effective July 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. 31. Minnesota Statutes 2024, section 256B.0757, subdivision 4c, is amended to read:

Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a licensed nurse, as defined in section 148.171, subdivision 9.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional who is qualified according to section 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner who is qualified according to section 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

(2) a mental health certified family peer specialist who is qualified according to section 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section ~~245G.07, subdivision 1, clause (5)~~ 245G.11, subdivision 8; or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

EFFECTIVE DATE. This section is effective July 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 2024, section 256B.0761, subdivision 4, is amended to read:

Subd. 4. **Services and duration.** (a) Services must be provided 90 days prior to an individual's release date or, if an individual's confinement is less than 90 days, during the time period between a medical assistance eligibility determination and the release to the community.

(b) Facilities must offer the following services using either community-based or corrections-based providers:

(1) case management activities to address physical and behavioral health needs, including a comprehensive assessment of individual needs, development of a person-centered care plan, referrals and other activities to address assessed needs, and monitoring and follow-up activities;

(2) drug coverage in accordance with section 256B.0625, subdivision 13, including up to a 30-day supply of drugs upon release;

(3) substance use disorder comprehensive assessments according to section 254B.05, subdivision 5, paragraph (b), clause (2);

(4) treatment coordination services according to section 254B.05, subdivision 5, paragraph (b), clause (3);

(5) peer recovery support services according to sections 245I.04, subdivisions 18 and 19, and 254B.05, subdivision 5, paragraph (b), clause (4);

(6) substance use disorder individual and group counseling provided according to sections 245G.07, subdivision 1, paragraph (a), clause (1), and 254B.05;

(7) mental health diagnostic assessments as required under section 245I.10;

(8) group and individual psychotherapy as required under section 256B.0671;

(9) peer specialist services as required under sections 245I.04 and 256B.0615;

(10) family planning and obstetrics and gynecology services; ~~and~~

(11) physical health well-being and screenings and care for adults and youth; and

(12) medications and nonmedication treatment services for opioid use disorder under section 245G.22.

(c) Services outlined in this subdivision must only be authorized when an individual demonstrates medical necessity or other eligibility as required under this chapter or applicable state and federal laws.

Sec. 33. Minnesota Statutes 2024, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256K.10. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be

increased by three percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18~~;~~, and early intensive developmental behavioral intervention services under section 256B.0949~~; and substance use disorder services under chapter 254B,~~ must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

Sec. 34. **DIRECTION TO COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT STAFF REPORT AND RECOMMENDATIONS.**

The commissioner of human services must, in consultation with the Board of Nursing, Board of Behavioral Health and Therapy, and Board of Medical Practice, conduct a study

and develop recommendations to the legislature for amendments to Minnesota Statutes, chapter 245G, that would eliminate any limitations on licensed health professionals' ability to provide substance use disorder treatment services while practicing within their licensed or statutory scopes of practice. The commissioner must submit a report on the study and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy by January 15, 2027.

Sec. 35. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT BILLING UNITS.**

The commissioner of human services must establish six new billing codes for nonresidential substance use disorder individual and group counseling, individual and group psychoeducation, and individual and group recovery support services. The commissioner must identify reimbursement rates for the newly defined codes and update the substance use disorder fee schedule. The new billing codes must correspond to a 15-minute unit and become effective for services provided on or after July 1, 2026, or upon federal approval, whichever is later.

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

Sec. 36. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the House Research Department; the Office of Senate Counsel, Research and Fiscal Analysis; and the Department of Human Services shall make necessary cross-reference changes and remove statutory cross-references in Minnesota Statutes to conform with the renumbering in this act. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text. The revisor may alter the coding in this act to incorporate statutory changes made by other law in the 2025 regular legislative session or a special session. If a provision stricken in this act is also amended in the 2025 regular legislative session or a special session by other law, the revisor shall merge the amendment into the numbering, notwithstanding Minnesota Statutes, section 645.30.

Sec. 37. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber each provision of Minnesota Statutes listed in column A as amended in this act to the number listed in column B. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

Column A	Column B
254B.05, subdivision 1, paragraph (a)	254B.0501, subdivision 1
254B.05, subdivision 1, paragraph (i)	254B.0501, subdivision 2
254B.05, subdivision 4	254B.0501, subdivision 3
254B.05, subdivision 1, paragraph (b)	254B.0501, subdivision 4
254B.05, subdivision 1, paragraph (c)	254B.0501, subdivision 5
254B.05, subdivision 1, paragraph (d)	254B.0501, subdivision 6, paragraph (a)
254B.05, subdivision 1, paragraph (e)	254B.0501, subdivision 6, paragraph (b)
254B.05, subdivision 1, paragraph (f)	254B.0501, subdivision 6, paragraph (c)
254B.05, subdivision 1, paragraph (g)	254B.0501, subdivision 6, paragraph (d)
254B.05, subdivision 1, paragraph (h)	254B.0501, subdivision 7
254B.05, subdivision 1b	254B.0501, subdivision 8
254B.05, subdivision 2	254B.0501, subdivision 9
254B.05, subdivision 3	254B.0501, subdivision 10
254B.05, subdivision 1a, paragraph (a)	254B.0503, subdivision 1, paragraph (a)
254B.05, subdivision 1a, paragraph (c)	254B.0503, subdivision 1, paragraph (b)
254B.05, subdivision 1a, paragraph (d)	254B.0503, subdivision 1, paragraph (c)
254B.05, subdivision 1a, paragraph (e)	254B.0503, subdivision 1, paragraph (d)
254B.05, subdivision1a, paragraph (b)	254B.0503, subdivision 2, paragraph (a)
254B.05, subdivision 1a, paragraph (e)	254B.0503, subdivision 2, paragraph (b)
254B.05, subdivision 5, paragraph (a)	254B.0505, subdivision 1
254B.05, subdivision 5, paragraph (c)	254B.0505, subdivision 2
254B.05, subdivision 5, paragraph (d)	254B.0505, subdivision 3
254B.05, subdivision 5, paragraph (e)	254B.0505, subdivision 4
254B.05, subdivision 5, paragraph (f)	254B.0505, subdivision 5
254B.05, subdivision 5, paragraph (g)	254B.0505, subdivision 6
254B.05, subdivision 5, paragraph (h)	254B.0505, subdivision 7
254B.05, subdivision 5, paragraph (i)	254B.0505, subdivision 8
254B.05, subdivision 5, paragraph (b), first sentence	254B.0507, subdivision 1
254B.05, subdivision 5, paragraph (b), clause (1), items (i) and (ii)	254B.0507, subdivision 2, paragraph (a)
254B.05, subdivision 5, paragraph (b), block left paragraph	254B.0507, subdivision 2, paragraph (b)

254B.05, subdivision 5, paragraph (b), clause (2)	254B.0507, subdivision 3
254B.05, subdivision 5, paragraph (b), clause (3)	254B.0507, subdivision 4
254B.05, subdivision 5, paragraph (b), clause (4)	254B.0507, subdivision 5
254B.05, subdivision 5, paragraph (b), clause (5)	254B.0507, subdivision 6, paragraph (a)
254B.05, subdivision 5, paragraph (b), clause (5), block left paragraph	254B.0507, subdivision 6, paragraph (b)
254B.05, subdivision 6, paragraph (a)	254B.0509, subdivision 1
254B.05, subdivision 6, paragraph (b)	254B.0509, subdivision 2
254B.05, subdivision 1, paragraph (j)	254B.052, subdivision 4
254B.05, subdivision 5, paragraph (j)	254B.052, subdivision 5

Sec. 38. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the terms "mental health practitioner" and "mental health practitioners" to "behavioral health practitioner" or "behavioral health practitioners" wherever they appear in Minnesota Statutes, chapter 245I.

Sec. 39. **REPEALER.**

Minnesota Statutes 2024, sections 245G.01, subdivision 20d; 245G.07, subdivision 2; 254B.01, subdivision 5; and 254B.18, are repealed.

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

ARTICLE 5
HOUSING SUPPORTS

Section 1. Minnesota Statutes 2024, section 256I.05, is amended by adding a subdivision to read:

Subd. 1v. **Supplemental rate; Blue Earth County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2025, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Blue Earth County that operates a long-term residential facility that opened in 2007 in Garden City with a total of 20 beds that serves chemically dependent women and provides 24-hour-a-day supervision and other support services.

Sec. 2. Minnesota Statutes 2024, section 256I.05, is amended by adding a subdivision to read:

Subd. 1w. **Supplemental rate; Otter Tail County.** Notwithstanding the provisions in this section, beginning July 1, 2025, a county agency shall negotiate a supplemental rate for up to 24 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for housing support providers located in Otter Tail County that operate facilities and provide room and board and supplementary services to adults recovering from substance use disorder, mental illness, or housing instability.

ARTICLE 6
HEALTH CARE

Section 1. Minnesota Statutes 2024, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the commissioner shall review all medical evidence and seek information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Medical assistance providers must grant the state medical review team access to electronic health records held by the medical assistance providers, when available, to support efficient and accurate disability determinations.

(c) Medicaid providers shall accept electronically signed authorizations to release medical records provided by the state medical review team.

~~(b)~~ (d) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

~~(c)~~ (e) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not

issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Sec. 2. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 29a. **State medical review team; expedited disability determinations.** (a) The commissioner must establish an expedited disability determination process within the state medical review team for applicants in the following high-risk categories:

(1) individuals in a facility who cannot be discharged without home- and community-based services or long-term care supports in place;

(2) individuals experiencing life-threatening medical conditions requiring urgent access to treatment or prescription medication;

(3) individuals diagnosed with a condition listed on the Social Security Administration's Compassionate Allowance List; and

(4) children under the age of two who have screened positive for a rare disease recognized by national medical registries or evidence-based standards.

(b) Hospitals submitting requests under paragraph (a) must complete an application for medical assistance prior to an expedited request and assist patients with returning required documentation necessary to determine disability.

(c) The commissioner must designate staff within the state medical review team to coordinate expedited requests, communicate with county and tribal agencies, and ensure timely electronic transmission of required documentation, including the use of electronic signature platforms.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, subdivision 17, is amended to read:

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

(b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

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

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

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

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

(4) public transportation, within the meaning of "public transportation" as defined in section 174.22, subdivision 7; or

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

(i) Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

(j) Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(k) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(l) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(m) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (l) according to paragraphs (p) and (q) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(n) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(o) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(p) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (k), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate for the first 100 miles and an additional $75 for trips over 100 miles and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(q) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (p), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (p), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (p), clauses (1) to (7).

(r) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (p) and (q), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(s) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (p) and (q), shall exempt all modes of transportation listed under paragraph (l) from Minnesota Rules, part 9505.0445, item R, subitem (2).

(t) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (p) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

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

Sec. 4. Minnesota Statutes 2024, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** ~~(a)~~ Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation.

Subd. 2. **Classification of therapies as basic care services.** ~~Effective July 1, 2010,~~ The commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in ~~this paragraph~~ subdivision 1 shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~ Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1

effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

Subd. 4. **Temporary payment reductions effective September 1, 2011.** ~~(c)~~ (a) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

~~(d)~~ (b) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

Subd. 5. **Payment increases effective September 1, 2014.** ~~(e)~~ (a) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent.

(b) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this ~~paragraph~~ subdivision.

Subd. 6. **Temporary payment reductions effective July 1, 2014.** ~~(f)~~ Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent.

Subd. 7. **Payment increases effective July 1, 2015.** (a) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under ~~paragraphs (i) and (j)~~ subdivisions 9 and 10.

~~(g)~~ (b) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified

in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under ~~this~~ paragraph (b).

Subd. 8. **Exempt services.** ~~(h)~~ This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

Subd. 9. **Individually priced items.** ~~(i)~~ (a) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service.

(b) This ~~paragraph~~ subdivision does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item.

(c) The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

Subd. 10. **Rate increases effective July 1, 2015.** ~~(j)~~ (a) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

~~This~~ (b) Paragraph (a) does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in ~~paragraph (i)~~ subdivision 9.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this ~~paragraph~~ subdivision.

Subd. 11. **Rates for ventilators.** ~~(k)~~ (a) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate.

(b) Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

(c) For payments made in accordance with this ~~paragraph~~ subdivision, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this ~~paragraph~~ subdivision.

Subd. 12. **Rates subject to the upper payment limit.** ~~(l)~~ Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this ~~paragraph~~ subdivision.

Subd. 13. **Temporary rates for enteral nutrition and supplies.** ~~(m)~~ (a) For dates of service on or after July 1, 2023, through June 30, ~~2025~~ 2027, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate must be the payment rate in effect on June 30, 2023.

(b) This subdivision expires June 30, 2027.

Subd. 14. **Rates for enteral nutrition and supplies.** ~~(n)~~ For dates of service on or after July 1, ~~2025~~ 2027, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision and updated annually each January 1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner for the previous calendar year, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment must be the manufacturer's suggested retail price of that product or supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment must be the actual acquisition cost of that product or supply plus 20 percent.

Sec. 5. **SINGLE ADMINISTRATIVE STRUCTURE AND DELIVERY SYSTEM PILOT PROGRAM.**

(a) By January 1, 2026, the commissioner of human services, in coordination with the commissioner of transportation, must implement one or two pilot programs for a web-based single administrative structure and delivery system for nonemergency medical transportation under medical assistance and MinnesotaCare. The administrative structure and delivery system must meet the requirements in paragraph (b). Each pilot program must include at least two counties. Metropolitan counties, as defined in Minnesota Statutes, section 473.121, subdivision 4, are not eligible to participate. Each pilot program shall operate for three years from the date of implementation.

(b) The web-based single administrative structure and delivery system must provide for the following:

(1) bidirectional communication between payers and transportation providers;

(2) client and client advocate access to ride scheduling and real-time trip monitoring;

(3) real-time eligibility and level of service determination;

(4) on-demand reporting;

(5) expedited payments for transportation providers; and

(6) the ability to collect feedback, including but not limited to complaints regarding inappropriate level of needs determinations, utilization of inappropriate transportation modes, and interference with accessing nonemergency medical transportation.

(c) By February 1, 2027, and each year thereafter that a pilot program is in effect, the commissioner must submit a report on the pilot programs to the chairs and ranking minority members of the legislative committees with jurisdiction over nonemergency medical transportation under medical assistance and MinnesotaCare.

ARTICLE 7
DIRECT CARE AND TREATMENT

Section 1. **[246.0142] FREE COMMUNICATION SERVICES FOR PATIENTS AND CLIENTS.**

Subdivision 1. **Free communication services.** The commissioner of human services and the Direct Care and Treatment executive board and all facilities, settings, and programs owned, operated, or under the programmatic or fiscal control of the commissioner of human services or the Direct Care and Treatment executive board are subject to section 241.252. The commissioner and executive board must not include the cost of voice or other communication services in the cost of care as defined under section 246.50 or 246B.01.

Subd. 2. **Communication service restrictions.** Notwithstanding section 241.252, subdivisions 2 and 4, nothing in this section entitles a civilly committed person to communication services restricted or limited under section 253B.03, subdivision 3, or 253D.19.

Sec. 2. Minnesota Statutes 2024, section 611.43, is amended by adding a subdivision to read:

Subd. 5. **Costs related to confined treatment.** (a) When a defendant is ordered to participate in an examination in a treatment facility, a locked treatment facility, or a state-operated treatment facility under subdivision 1, paragraph (b), the facility shall bill the responsible health plan.

(b) The Direct Care and Treatment executive board shall determine the cost of confinement in a state-operated treatment facility based on the executive board's determination of cost of care pursuant to section 246.50, subdivision 5.

Sec. 3. Minnesota Statutes 2024, section 611.46, subdivision 1, is amended to read:

Subdivision 1. **Order to competency attainment program.** (a) If the court finds the defendant incompetent and the charges have not been dismissed, the court shall order the defendant to participate in a program to assist the defendant in attaining competency. The court may order participation in a competency attainment program provided outside of a jail, a jail-based competency attainment program, or an alternative program. The court must determine the least-restrictive program appropriate to meet the defendant's needs and public safety. In making this determination, the court must consult with the forensic navigator and consider any recommendations of the court examiner. The court shall not order a defendant to participate in a jail-based program or a state-operated treatment program if the highest criminal charge is a targeted misdemeanor.

(b) If the court orders the defendant to a locked treatment facility or jail-based program, the court must calculate the defendant's custody credit and cannot order the defendant to a locked treatment facility or jail-based program for a period that would cause the defendant's custody credit to exceed the maximum sentence for the underlying charge.

(c) The court may only order the defendant to participate in competency attainment at an inpatient or residential treatment program under this section if the head of the treatment program determines that admission to the program is clinically appropriate and consents to the defendant's admission. The court may only order the defendant to participate in competency attainment at a state-operated treatment facility under this section if the Direct Care and Treatment executive board or a designee determines that admission of the defendant is clinically appropriate and consents to the defendant's admission. The court may require a competency program that qualifies as a locked facility or a state-operated treatment program to notify the court in writing of the basis for refusing consent for admission of the defendant in order to ensure transparency and maintain an accurate record. The court may not require personal appearance of any representative of a competency program. The court shall send a written request for notification to the locked facility or state-operated treatment program and the locked facility or state-operated treatment program shall provide a written response to the court within ten days of receipt of the court's request.

(d) If the defendant is confined in jail and has not received competency attainment services within 30 days of the finding of incompetency, the court shall review the case with input from the prosecutor and defense counsel and may:

(1) order the defendant to participate in an appropriate competency attainment program that takes place outside of a jail;

(2) order a conditional release of the defendant with conditions that include but are not limited to a requirement that the defendant participate in a competency attainment program when one becomes available and accessible;

(3) make a determination as to whether the defendant is likely to attain competency in the reasonably foreseeable future and proceed under section 611.49; or

(4) upon a motion, dismiss the charges in the interest of justice.

(e) The court may order any hospital, treatment facility, or correctional facility that has provided care or supervision to a defendant in the previous two years to provide copies of the defendant's medical records to the competency attainment program or alternative program in which the defendant was ordered to participate. This information shall be provided in a consistent and timely manner and pursuant to all applicable laws.

(f) If at any time the defendant refuses to participate in a competency attainment program or an alternative program, the head of the program shall notify the court and any entity responsible for supervision of the defendant.

(g) At any time, the head of the program may discharge the defendant from the program or facility. The head of the program must notify the court, prosecutor, defense counsel, and any entity responsible for the supervision of the defendant prior to any planned discharge. Absent emergency circumstances, this notification shall be made five days prior to the discharge if the defendant is not being discharged to jail or a correctional facility. Upon the receipt of notification of discharge or upon the request of either party in response to notification of discharge, the court may order that a defendant who is subject to bail or unmet conditions of release be returned to jail upon being discharged from the program or facility. If the court orders a defendant returned to jail, the court shall notify the parties and head of the program at least one day before the defendant's planned discharge, except in the event of an emergency discharge where one day notice is not possible. The court must hold a review hearing within seven days of the defendant's return to jail. The forensic navigator must be given notice of the hearing and be allowed to participate.

(h) If the defendant is discharged from the program or facility under emergency circumstances, notification of emergency discharge shall include a description of the emergency circumstances and may include a request for emergency transportation. The court shall make a determination on a request for emergency transportation within 24 hours. Nothing in this section prohibits a law enforcement agency from transporting a defendant pursuant to any other authority.

(i) If the defendant is ordered to participate in an inpatient or residential competency attainment or alternative program, the program or facility must notify the court, prosecutor, defense counsel, forensic navigator, and any entity responsible for the supervision of the defendant if the defendant is placed on a leave or elopement status from the program and if the defendant returns to the program from a leave or elopement status.

(j) Defense counsel, prosecutors, and forensic navigators must have access to information relevant to a defendant's participation and treatment in a competency attainment program or alternative program, including but not limited to discharge planning.

Sec. 4. Minnesota Statutes 2024, section 611.55, is amended by adding a subdivision to read:

Subd. 5. **Data access.** Forensic navigators must have access to all data collected, created, or maintained by a competency attainment program or an alternative program regarding a defendant in order for navigators to carry out their duties under this section. A competency attainment program or alternative program may request a copy of the court order appointing the forensic navigator before disclosing any private information about a defendant.

ARTICLE 8
DEPARTMENT OF DIRECT CARE AND TREATMENT ESTABLISHMENT

Section 1. Minnesota Statutes 2024, section 10.65, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given:

(1) "agency" means the Department of Administration; Department of Agriculture; Department of Children, Youth, and Families; Department of Commerce; Department of Corrections; Department of Direct Care and Treatment; Department of Education; Department of Employment and Economic Development; Department of Health; Office of Higher Education; Housing Finance Agency; Department of Human Rights; Department of Human Services; Department of Information Technology Services; Department of Iron Range Resources and Rehabilitation; Department of Labor and Industry; Minnesota Management and Budget; Bureau of Mediation Services; Department of Military Affairs; Metropolitan Council; Department of Natural Resources; Pollution Control Agency; Department of Public Safety; Department of Revenue; Department of Transportation; Department of Veterans Affairs; ~~Direct Care and Treatment;~~ Gambling Control Board; Racing Commission; the Minnesota Lottery; the Animal Health Board; the Public Utilities Commission; and the Board of Water and Soil Resources;

(2) "consultation" means the direct and interactive involvement of the Minnesota Tribal governments in the development of policy on matters that have Tribal implications. Consultation is the proactive, affirmative process of identifying and seeking input from appropriate Tribal governments and considering their interest as a necessary and integral part of the decision-making process. This definition adds to statutorily mandated notification procedures. During a consultation, the burden is on the agency to show that it has made a good faith effort to elicit feedback. Consultation is a formal engagement between agency officials and the governing body or bodies of an individual Minnesota Tribal government that the agency or an individual Tribal government may initiate. Formal meetings or communication between top agency officials and the governing body of a Minnesota Tribal government is a necessary element of consultation;

(3) "matters that have Tribal implications" means rules, legislative proposals, policy statements, or other actions that have substantial direct effects on one or more Minnesota Tribal governments, or on the distribution of power and responsibilities between the state and Minnesota Tribal governments;

(4) "Minnesota Tribal governments" means the federally recognized Indian Tribes located in Minnesota including: Bois Forte Band; Fond Du Lac Band; Grand Portage Band; Leech Lake Band; Mille Lacs Band; White Earth Band; Red Lake Nation; Lower Sioux Indian Community; Prairie Island Indian Community; Shakopee Mdewakanton Sioux Community; and Upper Sioux Community; and

(5) "timely and meaningful" means done or occurring at a favorable or useful time that allows the result of consultation to be included in the agency's decision-making process for a matter that has Tribal implications.

Sec. 2. Minnesota Statutes 2024, 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 Children, Youth, and Families; 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 Revenue; the Department of Transportation; the Department of Veterans Affairs; and their successor departments.

Sec. 3. Minnesota Statutes 2024, 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; Children, Youth, and Families; Commerce; Corrections; Direct Care and Treatment; Education; Employment and Economic Development; Health; Human Rights; Human Services; Iron Range Resources and Rehabilitation; Labor and Industry; Management and Budget; Natural Resources; Public Safety; Revenue; Transportation; and Veterans Affairs; the Housing Finance and Pollution Control Agencies; 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."

Sec. 4. Minnesota Statutes 2024, section 43A.241, is amended to read:

43A.241 INSURANCE CONTRIBUTIONS; FORMER EMPLOYEES.

(a) This section applies to a person who:

(1) was employed by the commissioner of corrections, the commissioner of human services, or the commissioner of direct care and treatment ~~executive board~~;

(2) was covered by the correctional employee retirement plan under section 352.91 or the general state employees retirement plan of the Minnesota State Retirement System as defined in section 352.021;

(3) while employed under clause (1), was assaulted by:

(i) a person under correctional supervision for a criminal offense; or

(ii) a client or patient at the Minnesota Sex Offender Program, or at a state-operated forensic services program as defined in section 352.91, subdivision 3j; and

(4) as a direct result of the assault under clause (3), was determined to be totally and permanently physically disabled under laws governing the Minnesota State Retirement System.

(b) For a person to whom this section applies, the commissioner of corrections, the commissioner of human services, or the commissioner of direct care and treatment ~~executive board~~, using existing budget resources, must continue to make the employer contribution for medical and dental benefits under the State Employee Group Insurance Program after

the person terminates state service. If the person had dependent coverage at the time of terminating state service, employer contributions for dependent coverage also must continue under this section. The employer contributions must be in the amount of the employer contribution for active state employees at the time each payment is made. The employer contributions must continue until the person reaches age 65, provided the person makes the required employee contributions, in the amount required of an active state employee, at the time and in the manner specified by the commissioner ~~or executive board~~.

Sec. 5. Minnesota Statutes 2024, section 246C.01, is amended to read:

246C.01 TITLE.

This chapter may be cited as the "Department of Direct Care and Treatment Act."

Sec. 6. Minnesota Statutes 2024, section 246C.015, subdivision 3, is amended to read:

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of ~~human services~~ direct care and treatment.

Sec. 7. Minnesota Statutes 2024, section 246C.015, is amended by adding a subdivision to read:

Subd. 5b. **Department.** "Department" means the Department of Direct Care and Treatment.

Sec. 8. Minnesota Statutes 2024, section 246C.02, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The Department of Direct Care and Treatment is ~~created as an agency headed by an executive board~~ established.

Sec. 9. Minnesota Statutes 2024, section 246C.04, subdivision 2, is amended to read:

Subd. 2. **Transfer of custody of civilly committed persons.** The commissioner of human services shall continue to exercise all authority and responsibility for and retain custody of persons subject to civil commitment under chapter 253B or 253D until July 1, 2025. Effective July 1, 2025, custody of persons subject to civil commitment under chapter 253B or 253D and in the custody of the commissioner of human services as of that date is hereby transferred to the ~~executive board~~ commissioner without any further act or proceeding. Authority and responsibility for the commitment of such persons is transferred to the ~~executive board~~ commissioner July 1, 2025.

Sec. 10. Minnesota Statutes 2024, section 246C.04, subdivision 3, is amended to read:

Subd. 3. **Control of direct care and treatment.** The commissioner of human services shall continue to exercise all authorities and responsibilities under this chapter and chapters 13, 245, 246, 246B, 252, 253, 253B, 253C, 253D, 254A, 254B, and 256, with reference to any state-operated service, program, or facility subject to transfer under Laws 2024, chapter 79; Laws 2024, chapter 125, article 5; and Laws 2024, chapter 127, article 50, until July 1, 2025. Effective July 1, 2025, the powers and duties vested in or imposed upon the commissioner of human services with reference to any state-operated service, program, or facility are hereby transferred to, vested in, and imposed upon the ~~executive board~~ commissioner according to this chapter and applicable state law. Effective July 1, 2025, the ~~executive board~~ commissioner has the exclusive power of administration and management of all state hospitals for persons with a developmental disability, mental illness, or substance use disorder. Effective July 1, 2025, the ~~executive board~~ commissioner has the power and authority to determine all matters relating to the development of all of the foregoing institutions and of such other institutions vested in the ~~executive board~~ commissioner. Effective July 1, 2025, the powers, functions, and authority vested in the commissioner of human services relative to such state institutions are transferred to the ~~executive board~~ commissioner according to this chapter and applicable state law.

Sec. 11. Minnesota Statutes 2024, section 246C.07, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) The ~~executive board~~ commissioner must operate the ~~agency~~ department according to this chapter and applicable state and federal law. The overall management and control of the ~~agency~~ department is vested in the ~~executive board~~ commissioner in accordance with this chapter.

(b) The ~~executive board~~ commissioner must appoint a chief executive officer according to section 246C.08. The chief executive officer is responsible for the administrative and operational duties of the Department of Direct Care and Treatment in accordance with this chapter and serves as the deputy commissioner for the purposes of section 15.06 and as deputy agency head for the purposes of section 43A.08.

(c) The ~~executive board~~ commissioner may delegate duties imposed by this chapter and under applicable state and federal law as deemed appropriate by the ~~board~~ commissioner and in accordance with this chapter. Any delegation of a specified statutory duty or power to an employee of the Department of Direct Care and Treatment other than the chief executive officer must be made by written order and filed with the secretary of state. Only the chief

executive officer shall have the powers and duties of the ~~executive board~~ commissioner as specified in section 246C.08.

Sec. 12. Minnesota Statutes 2024, section 246C.07, subdivision 2, is amended to read:

Subd. 2. **Principles.** The ~~executive board~~ commissioner, in undertaking ~~its~~ the commissioner's duties and responsibilities and within the Department of Direct Care and Treatment resources, shall act according to the following principles:

(1) prevent the waste or unnecessary spending of public money;

(2) use innovative fiscal and human resource practices to manage the state's resources and operate the ~~agency~~ department as efficiently as possible;

(3) coordinate Department of Direct Care and Treatment activities wherever appropriate with the activities of other governmental agencies;

(4) use technology where appropriate to increase ~~agency~~ department productivity, improve customer service, increase public access to information about government, and increase public participation in the business of government; and

(5) utilize constructive and cooperative labor management practices to the extent otherwise required by chapter 43A or 179A.

Sec. 13. Minnesota Statutes 2024, section 246C.07, subdivision 8, is amended to read:

Subd. 8. **Biennial estimates; suggestions for legislation.** The ~~executive board~~ commissioner shall prepare, for the use of the legislature, biennial estimates of appropriations necessary or expedient to be made for the support of the institutions and for extraordinary and special expenditures for buildings and other improvements. The ~~executive board~~ commissioner shall make suggestions relative to legislation for the benefit of the institutions. The ~~executive board~~ commissioner shall report the estimates and suggestions to the legislature on or before November 15 in each even-numbered year. ~~A designee of the executive board~~ The commissioner on request shall appear before any legislative committee and furnish any required information in regard to the condition of any such institution.

Sec. 14. **[246C.075] ADVISORY COUNCIL ON DIRECT CARE AND TREATMENT.**

Subdivision 1. **Establishment.** An Advisory Council on Direct Care and Treatment is established.

Subd. 2. **Membership.** (a) The Advisory Council on Direct Care and Treatment must consist of no more than 15 members appointed as provided in section 15.0597. The advisory council must include:

(1) one member who is a licensed physician with experience serving behavioral health patients or a licensed psychiatrist, appointed by the commissioner;

(2) two members with executive management experience at a hospital or health care system, or experience serving on the board of a hospital or health care system, appointed by the commissioner;

(3) three members, each appointed by the commissioner, who have experience working:

(i) in the delivery of behavioral health services;

(ii) in care coordination;

(iii) in traditional healing practices;

(iv) as a licensed health care professional;

(v) within health care administration; or

(vi) with residential services;

(4) one member appointed by the Association of Counties;

(5) one member who has an active role as a union representative representing staff at the Department of Direct Care and Treatment appointed by joint representatives of the following unions: American Federation of State, County, and Municipal Employees (AFSCME); Minnesota Association of Professional Employees (MAPE); Minnesota Nurses Association (MNA); Middle Management Association (MMA); and State Residential Schools Education Association (SRSEA);

(6) one member appointed by the National Alliance on Mental Illness Minnesota;

(7) two members representing people with lived experience being served by state-operated treatment programs or their families, appointed by the commissioner;

(8) one member appointed by the Minnesota Disability Law Center; and

(9) up to three additional members appointed by the commissioner reflecting community interests or perspectives the commissioner deems valuable.

(b) Membership on the advisory council must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

(c) Appointing authorities under paragraph (a) must make initial appointments by September 1, 2025.

Subd. 3. **Terms; compensation; removal; vacancies; expiration.** (a) The membership terms, compensation, removal of members, and filling of vacancies of members are as provided in section 15.059, except that council members shall not receive a per diem.

(b) The advisory council does not expire.

Subd. 4. **Meetings.** (a) The members of the advisory council shall elect a chair from among their membership at the first meeting and annually thereafter or upon a vacancy in the chair. The advisory council shall meet at the call of the commissioner, the call of the chair, or upon the call of a majority of members.

(b) The first meeting of the advisory council must be held no later than September 15, 2025.

Subd. 5. **Duties.** The advisory council shall advise the commissioner regarding the operations of the Department of Direct Care and Treatment, the clinical standards of care for patients and clients of state-operated programs, and provide recommendations to the commissioner for improving the department's role in the state's mental health care system.

Sec. 15. Minnesota Statutes 2024, section 246C.08, is amended to read:

246C.08 CHIEF EXECUTIVE OFFICER; SERVICE; DUTIES.

Subdivision 1. **Service.** (a) The direct care and treatment chief executive officer is appointed by the ~~executive board, in consultation with the governor, and serves at the pleasure of the executive board, with the advice and consent of the senate~~ commissioner, and is the deputy commissioner for the purposes of section 15.06.

(b) The chief executive officer shall serve in the unclassified service in accordance with section 43A.08. ~~The Compensation Council under section 15A.082 shall establish the salary of the chief executive officer.~~

Subd. 2. **Powers and duties.** (a) The chief executive officer's primary duty is to assist the ~~executive board~~ commissioner. The chief executive officer is responsible for the administrative and operational management of the agency.

~~(b) The chief executive officer shall have all the powers of the executive board unless the executive board directs otherwise. The chief executive officer shall have the authority to speak for the executive board and Direct Care and Treatment within and outside the agency.~~

~~(c)~~ (b) In the event that a vacancy occurs for any reason within the chief executive officer position, the executive medical director appointed under section 246C.09 shall immediately become the temporary chief executive officer until the ~~executive board~~ commissioner appoints a new chief executive officer. During this period, the executive medical director shall have all the powers and authority delegated to the chief executive officer by the ~~board~~ commissioner and specified in this chapter.

Subd. 3. **Minimum qualifications.** The chief executive officer must be selected by the commissioner without regard to political affiliation and must have wide and successful administrative experience in and understanding of health care, preferably behavioral health care, including clinical and operational needs of a large health care service and delivery organization.

EFFECTIVE DATE. This section is effective July 1, 2025, except the amendment to subdivision 1, paragraph (b), is effective retroactively from July 1, 2024.

Sec. 16. Minnesota Statutes 2024, section 246C.09, subdivision 3, is amended to read:

Subd. 3. **Duties.** The executive medical director shall:

(1) oversee the clinical provision of inpatient mental health services provided in the state's regional treatment centers;

(2) recruit and retain psychiatrists to serve on the ~~Direct Care and Treatment~~ department medical staff established in subdivision 4;

(3) consult with the ~~executive board, the chief executive officer,~~ commissioner, the chief executive officer, and community mental health center directors to develop standards for treatment and care of patients in state-operated service programs;

(4) develop and oversee a continuing education program for members of the medical staff; and

(5) participate and cooperate in the development and maintenance of a quality assurance program for state-operated services that assures that residents receive continuous quality inpatient, outpatient, and postdischarge care.

Sec. 17. Minnesota Statutes 2024, section 246C.091, subdivision 2, is amended to read:

Subd. 2. **Facilities management account.** A facilities management account is created in the special revenue fund of the state treasury. Beginning July 1, 2025, money in the account is appropriated to the commissioner of direct care and treatment ~~executive board~~

and may be used to maintain buildings, acquire facilities, renovate existing buildings, or acquire land for the design and construction of buildings for ~~Direct Care and Treatment~~ department use. Money received for maintaining state property under control of the ~~executive board~~ commissioner may be deposited into this account.

Sec. 18. Minnesota Statutes 2024, section 246C.091, subdivision 3, is amended to read:

Subd. 3. **Direct care and treatment systems account.** (a) The direct care and treatment systems account is created in the special revenue fund of the state treasury. Beginning July 1, 2025, money in the account is appropriated to the commissioner of direct care and treatment ~~executive board~~ and may be used for security systems and information technology projects, services, and support under the control of the ~~executive board~~ commissioner.

(b) The commissioner of human services shall transfer all money allocated to the direct care and treatment systems projects under section 256.014 to the direct care and treatment systems account under this section by June 30, 2026.

Sec. 19. Minnesota Statutes 2024, section 246C.091, subdivision 4, is amended to read:

Subd. 4. **Cemetery maintenance account.** The cemetery maintenance account is created in the special revenue fund of the state treasury. Money in the account is appropriated to the ~~executive board~~ commissioner of direct care and treatment for the maintenance of cemeteries under control of the ~~executive board~~ commissioner. Money allocated to ~~Direct Care and Treatment~~ department cemeteries may be transferred to this account.

Sec. 20. Laws 2024, chapter 127, article 50, section 41, subdivision 2, is amended to read:

Subd. 2. **Chief executive officer.** (a) The commissioner of direct care and treatment ~~executive board~~ must appoint as the initial chief executive officer for direct care and treatment under Minnesota Statutes, section ~~246C.07~~ 246C.08, the chief executive officer of the direct care and treatment division of the Department of Human Services holding that position at the time the initial appointment is made by the ~~board~~ commissioner. The initial appointment of the chief executive officer must be made by the ~~executive board~~ commissioner by July 1, 2025. ~~The initial appointment of the chief executive officer is subject to confirmation by the senate.~~

(b) ~~In its report issued April 1, 2025, the Compensation Council under Minnesota Statutes, section 15A.082, must establish the salary of the chief executive officer at an amount equal to or greater than the amount paid to the chief executive officer of the direct care and treatment division of the Department of Human Services as of the date of initial appointment.~~

~~The salary of the chief executive officer shall become effective July 1, 2025, pursuant to Minnesota Statutes, section 15A.082, subdivision 3. Notwithstanding Minnesota Statutes, sections 15A.082 and 246C.08, subdivision 1, if the initial appointment of the chief executive officer occurs prior to the effective date of the salary specified by the Compensation Council in its April 1, 2025, report, the~~ The initial salary of the chief executive officer must equal the amount paid to the chief executive officer of the direct care and treatment division of the Department of Human Services as of the date of initial appointment.

EFFECTIVE DATE. This section is effective July 1, 2025, except the amendment to paragraph (b) is effective retroactively from July 1, 2024.

Sec. 21. **INITIAL APPOINTMENT OF COMMISSIONER OF DIRECT CARE AND TREATMENT.**

The initial appointment of a commissioner of direct care and treatment or initial designation of a temporary commissioner of direct care and treatment by the governor under Minnesota Statutes, section 15.06, must be made by July 1, 2025. Notwithstanding Minnesota Statutes, section 15.066, subdivision 2, clause (4), the initial appointment of a commissioner of direct care and treatment or initial designation of a temporary commissioner of direct care and treatment is effective no earlier than July 1, 2025.

Sec. 22. **SALARY FOR THE COMMISSIONER OF THE DEPARTMENT OF DIRECT CARE AND TREATMENT.**

If the initial appointment of the commissioner of the Department of Direct Care and Treatment occurs prior to the commissioner's salary being determined by the Compensation Council under Minnesota Statutes, section 15A.082, the commissioner's salary must equal the salary of the commissioner of human services, as determined under Minnesota Statutes, section 15A.0815, subdivision 2.

EFFECTIVE DATE. This section is effective the day following final enactment and expires upon adoption by the Compensation Council of a salary for the position of commissioner of the Department of Direct Care and Treatment.

Sec. 23. **DISSOLUTION OF THE DIRECT CARE AND TREATMENT EXECUTIVE BOARD.**

Subdivision 1. **Dissolution of executive board.** Upon the effective date of this section, the direct care and treatment executive board under Minnesota Statutes, section 246C.06, is dissolved.

Subd. 2. **Transfer of duties.** (a) Any authorities and responsibilities that were vested in the executive board prior to July 1, 2025, are transferred to the commissioner of human services. Minnesota Statutes, section 15.039, applies to the transfer of responsibilities from the direct care and treatment executive board to the commissioner of human services between the effective date of this section and July 1, 2025.

(b) Minnesota Statutes, section 246C.04, governs the transfer of authority and responsibility on July 1, 2025, from the commissioner of human services to the commissioner of direct care and treatment.

Sec. 24. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "Direct Care and Treatment" to "the Department of Direct Care and Treatment" and "agency" to "department" wherever the terms appear in respect to the governmental entity with programmatic direction and fiscal control over state-operated services, programs, or facilities under Minnesota Statutes, chapter 246C. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

(b) The revisor of statutes shall change the term "executive board" to "commissioner" and "Direct Care and Treatment executive board" to "commissioner of direct care and treatment" wherever the terms appear in respect to the head of the governmental entity with programmatic direction and fiscal control over state-operated services, programs, or facilities under Minnesota Statutes, chapter 246C. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

Sec. 25. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the House Research Department; the Office of Senate Counsel, Research and Fiscal Analysis; the Department of Human Services; and the Department of Direct Care and Treatment, shall make necessary cross-reference changes to conform with this act. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text. The revisor may alter the coding in this act to incorporate statutory changes made by other law in the 2025 regular legislative session.

Sec. 26. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 246C.06, subdivision 11, as Minnesota Statutes, section 246C.07, subdivision 4a, and correct all cross-references.

Sec. 27. **REPEALER.**

(a) Minnesota Statutes 2024, sections 246C.015, subdivisions 5a and 6; 246C.06, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10; and 246C.07, subdivisions 4 and 5, are repealed.

(b) Laws 2024, chapter 79, article 1, section 20, is repealed.

(c) Laws 2024, chapter 125, article 5, sections 40; and 41; and Laws 2024, chapter 127, article 50, sections 40; and 41, subdivisions 1, and 3, are repealed retroactive to July 1, 2024.

Sec. 28. **EFFECTIVE DATE.**

This article is effective the day following final enactment.

ARTICLE 9

DEPARTMENT OF DIRECT CARE AND TREATMENT CONFORMING CHANGES

Section 1. Minnesota Statutes 2024, section 15A.0815, subdivision 2, is amended to read:

Subd. 2. **Agency head salaries.** The salary for a position listed in this subdivision shall be determined by the Compensation Council under section 15A.082. The commissioner of management and budget must publish the salaries on the department's website. This subdivision applies to the following positions:

Commissioner of administration;

Commissioner of agriculture;

Commissioner of education;

Commissioner of children, youth, and families;

Commissioner of commerce;

Commissioner of corrections;

Commissioner of health;

Commissioner, Minnesota Office of Higher Education;

Commissioner, Minnesota IT Services;

Commissioner, Housing Finance Agency;

Commissioner of human rights;

Commissioner of human services;

Commissioner of labor and industry;

Commissioner of management and budget;

Commissioner of natural resources;

Commissioner, Pollution Control Agency;

Commissioner of public safety;

Commissioner of revenue;

Commissioner of employment and economic development;

Commissioner of transportation;

Commissioner of veterans affairs;

Commissioner of direct care and treatment;

Executive director of the Gambling Control Board;

Executive director of the Minnesota State Lottery;

Executive director of the Office of Cannabis Management;

Commissioner of Iron Range resources and rehabilitation;

Commissioner, Bureau of Mediation Services;

Ombudsman for mental health and developmental disabilities;

Ombudsperson for corrections;

Chair, Metropolitan Council;

Chair, Metropolitan Airports Commission;

School trust lands director;

Executive director of pari-mutuel racing;

Commissioner, Public Utilities Commission;

~~Chief Executive Officer, Direct Care and Treatment;~~ and

Director of the Office of Emergency Medical Services.

EFFECTIVE DATE. This section is effective July 1, 2025, except the amendment striking "Chief Executive Officer, Direct Care and Treatment;" is effective retroactively from July 1, 2024.

Sec. 2. Minnesota Statutes 2024, section 15A.082, subdivision 1, is amended to read:

Subdivision 1. **Creation.** A Compensation Council is created each odd-numbered year to establish the compensation of constitutional officers and the heads of state and metropolitan agencies identified in section 15A.0815~~,~~ and to assist the legislature in establishing the compensation of justices of the supreme court and judges of the court of appeals and district court~~, and to determine the daily compensation for voting members of the Direct Care and Treatment executive board~~.

Sec. 3. Minnesota Statutes 2024, section 15A.082, subdivision 3, is amended to read:

Subd. 3. **Submission of recommendations and determination.** (a) By April 1 in each odd-numbered year, the Compensation Council shall submit to the speaker of the house and the president of the senate salary recommendations for justices of the supreme court, and judges of the court of appeals and district court. The recommended salaries take effect on July 1 of that year and July 1 of the subsequent even-numbered year and at whatever interval the council recommends thereafter, unless the legislature by law provides otherwise. The salary recommendations take effect if an appropriation of money to pay the recommended salaries is enacted after the recommendations are submitted and before their effective date. Recommendations may be expressly modified or rejected.

(b) By April 1 in each odd-numbered year, the Compensation Council must prescribe salaries for constitutional officers, and for the agency and metropolitan agency heads identified in section 15A.0815. The prescribed salary for each office must take effect July 1 of that year and July 1 of the subsequent even-numbered year and at whatever interval the council determines thereafter, unless the legislature by law provides otherwise. An appropriation by the legislature to fund the relevant office, branch, or agency of an amount sufficient to pay the salaries prescribed by the council constitutes a prescription by law as provided in the Minnesota Constitution, article V, sections 4 and 5.

~~(c) By April 1 in each odd-numbered year, the Compensation Council must prescribe daily compensation for voting members of the Direct Care and Treatment executive board. The recommended daily compensation takes effect on July 1 of that year and July 1 of the subsequent even-numbered year and at whatever interval the council recommends thereafter, unless the legislature by law provides otherwise.~~

Sec. 4. Minnesota Statutes 2024, section 15A.082, subdivision 7, is amended to read:

Subd. 7. **No ex parte communications.** Members may not have any communication with a constitutional officer, a head of a state agency, or a member of the judiciary~~, or a~~

~~member of the Direct Care and Treatment executive board~~ during the period after the first meeting is convened under this section and the date the prescribed and recommended salaries ~~and daily compensation~~ are submitted under subdivision 3.

Sec. 5. Minnesota Statutes 2024, section 43A.08, subdivision 1, is amended to read:

Subdivision 1. **Unclassified positions.** Unclassified positions are held by employees who are:

(1) chosen by election or appointed to fill an elective office;

(2) heads of agencies required by law to be appointed by the governor or other elective officers, and the executive or administrative heads of departments, bureaus, divisions, and institutions specifically established by law in the unclassified service;

(3) deputy and assistant agency heads and one confidential secretary in the agencies listed in subdivision 1a;

(4) the confidential secretary to each of the elective officers of this state and, for the secretary of state and state auditor, an additional deputy, clerk, or employee;

(5) intermittent help employed by the commissioner of public safety to assist in the issuance of vehicle licenses;

(6) employees in the offices of the governor and of the lieutenant governor and one confidential employee for the governor in the Office of the Adjutant General;

(7) employees of the Washington, D.C., office of the state of Minnesota;

(8) employees of the legislature and of legislative committees or commissions; provided that employees of the Legislative Audit Commission, except for the legislative auditor, the deputy legislative auditors, and their confidential secretaries, shall be employees in the classified service;

(9) presidents, vice-presidents, deans, other managers and professionals in academic and academic support programs, administrative or service faculty, teachers, research assistants, and student employees eligible under terms of the federal Economic Opportunity Act work study program in the Perpich Center for Arts Education and the Minnesota State Colleges and Universities, but not the custodial, clerical, or maintenance employees, or any professional or managerial employee performing duties in connection with the business administration of these institutions;

(10) officers and enlisted persons in the National Guard;

(11) attorneys, legal assistants, and three confidential employees appointed by the attorney general or employed with the attorney general's authorization;

(12) judges and all employees of the judicial branch, referees, receivers, jurors, and notaries public, except referees and adjusters employed by the Department of Labor and Industry;

(13) members of the State Patrol; provided that selection and appointment of State Patrol troopers must be made in accordance with applicable laws governing the classified service;

(14) examination monitors and intermittent training instructors employed by the Departments of Management and Budget and Commerce and by professional examining boards and intermittent staff employed by the technical colleges for the administration of practical skills tests and for the staging of instructional demonstrations;

(15) student workers;

(16) executive directors or executive secretaries appointed by and reporting to any policy-making board or commission established by statute;

(17) employees unclassified pursuant to other statutory authority;

(18) intermittent help employed by the commissioner of agriculture to perform duties relating to pesticides, fertilizer, and seed regulation;

(19) the administrators and the deputy administrators at the State Academies for the Deaf and the Blind; and

(20) the chief executive officer of Direct Care and Treatment who serves as the deputy agency head.

Sec. 6. Minnesota Statutes 2024, 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; Children, Youth, and Families; 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; 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; ~~Direct Care and Treatment;~~ the Minnesota Zoological Board; and the Office of Emergency Medical Services.

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.

Sec. 7. Minnesota Statutes 2024, section 245.021, is amended to read:

245.021 ~~DEFINITIONS~~ DEFINITION.

(a) For the purposes of this chapter, the ~~definitions~~ definition in this section ~~have~~ has the ~~meanings~~ meaning given ~~them~~.

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

~~(c) "Executive board" has the meaning given in section 246C.015.~~

Sec. 8. Minnesota Statutes 2024, section 245.073, is amended to read:

245.073 TECHNICAL TRAINING; COMMUNITY-BASED PROGRAMS.

(a) In conjunction with the discharge of persons from regional treatment centers and their admission to state-operated and privately operated community-based programs, the

commissioner may provide technical training assistance to the community-based programs. The commissioner may apply for and accept money from any source including reimbursement charges from the community-based programs for reasonable costs of training. Money received must be deposited in the general fund and is appropriated annually to the commissioner of human services for training under this section.

(b) The commissioner must coordinate with the ~~executive board~~ commissioner of direct care and treatment or the commissioner's designee to provide technical training assistance to community-based programs under this section and section 246C.11, subdivision 5.

Sec. 9. Minnesota Statutes 2024, section 246.13, subdivision 1, is amended to read:

Subdivision 1. **~~Executive board~~ Record responsibilities.** (a) The chief executive officer or a designee shall have, accessible only by consent of the ~~executive board~~ commissioner or on the order of a judge or court of record, a record showing:

(1) the residence, sex, age, nativity, occupation, civil condition, and date of entrance or commitment of every person, in the state-operated services facilities as defined under section 246C.02 under exclusive control of the ~~executive board~~ commissioner;

(2) the date of discharge of any such person and whether such discharge was final;

(3) the condition of the person when the person left the state-operated services facility;

(4) the vulnerable adult abuse prevention associated with the person; and

(5) the date and cause of any death of such person.

(b) The record in paragraph (a) must state every transfer of a person from one state-operated services facility to another, naming each state-operated services facility. The head of each facility or a designee must provide this transfer information to the ~~executive board~~ commissioner, along with other obtainable facts as the ~~executive board~~ commissioner requests.

(c) The head of the state-operated services facility or designee shall inform the ~~executive board~~ commissioner of any discharge, transfer, or death of a person in that facility within ten days of the date of discharge, transfer, or death in a manner determined by the ~~executive board~~ commissioner.

(d) The ~~executive board~~ commissioner shall maintain an adequate system of records and statistics for all basic record forms, including patient personal records and medical record forms. The use and maintenance of such records must be consistent throughout all state-operated services facilities.

Sec. 10. Minnesota Statutes 2024, section 246B.01, is amended by adding a subdivision to read:

Subd. 2e. **Commissioner.** "Commissioner" means the commissioner of direct care and treatment.

Sec. 11. Minnesota Statutes 2024, section 252.021, is amended by adding a subdivision to read:

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of human services.

Sec. 12. Minnesota Statutes 2024, section 252.50, subdivision 5, is amended to read:

Subd. 5. **Location of programs.** (a) In determining the location of state-operated, community-based programs, the needs of the individual client shall be paramount. The ~~executive board~~ commissioner of direct care and treatment shall also take into account:

(1) prioritization of beds in state-operated, community-based programs for individuals with complex behavioral needs that cannot be met by private community-based providers;

(2) choices made by individuals who chose to move to a more integrated setting, and shall coordinate with the lead agency to ensure that appropriate person-centered transition plans are created;

(3) the personal preferences of the persons being served and their families as determined by Minnesota Rules, parts 9525.0004 to 9525.0036;

(4) the location of the support services established by the individual service plans of the persons being served;

(5) the appropriate grouping of the persons served;

(6) the availability of qualified staff;

(7) the need for state-operated, community-based programs in the geographical region of the state; and

(8) a reasonable commuting distance from a regional treatment center or the residences of the program staff.

(b) The ~~executive board~~ commissioner of direct care and treatment must locate state-operated, community-based programs in coordination with the commissioner of human services according to section 252.28.

Sec. 13. Minnesota Statutes 2024, section 253.195, is amended by adding a subdivision to read:

Subd. 2a. **Commissioner.** "Commissioner" means the commissioner of direct care and treatment.

Sec. 14. Minnesota Statutes 2024, section 253B.02, is amended by adding a subdivision to read:

Subd. 2a. **Commissioner.** "Commissioner" means the commissioner of direct care and treatment.

Sec. 15. Minnesota Statutes 2024, section 253B.02, subdivision 3, is amended to read:

Subd. 3. **Commissioner of human services.** "Commissioner of human services" means the commissioner of human services or the commissioner's designee.

Sec. 16. Minnesota Statutes 2024, section 253B.02, subdivision 4c, is amended to read:

Subd. 4c. **County of financial responsibility.** (a) "County of financial responsibility" has the meaning specified in chapter 256G. This definition does not require that the person qualifies for or receives any other form of financial, medical, or social service assistance in addition to the services under this chapter. Disputes about the county of financial responsibility shall be submitted for determination to the ~~executive board~~ commissioner through the commissioner of human services in the manner prescribed in section 256G.09.

(b) For purposes of proper venue for filing a petition pursuant to section 253B.064, subdivision 1, paragraph (a); 253B.07, subdivision 1, paragraph (a); or 253D.07, where the designated agency of a county has determined that it is the county of financial responsibility, then that county is the county of financial responsibility until a different determination is made by the appropriate county agencies or the commissioner of human services pursuant to chapter 256G.

Sec. 17. Minnesota Statutes 2024, section 253B.03, subdivision 7, is amended to read:

Subd. 7. **Treatment plan.** A patient receiving services under this chapter has the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary. The treatment facility, state-operated treatment program, or community-based treatment program shall devise a written treatment plan for each patient which describes in behavioral terms the case problems, the precise goals, including the expected period of time for treatment, and the specific measures to be

employed. The development and review of treatment plans must be conducted as required under the license or certification of the treatment facility, state-operated treatment program, or community-based treatment program. If there are no review requirements under the license or certification, the treatment plan must be reviewed quarterly. The treatment plan shall be devised and reviewed with the designated agency and with the patient. The clinical record shall reflect the treatment plan review. If the designated agency or the patient does not participate in the planning and review, the clinical record shall include reasons for nonparticipation and the plans for future involvement. The commissioner of human services shall monitor the treatment plan and review process for state-operated treatment programs to ensure compliance with the provisions of this subdivision.

Sec. 18. Minnesota Statutes 2024, section 253B.041, subdivision 4, is amended to read:

Subd. 4. **Evaluation.** Counties may, but are not required to, provide engagement services. The commissioner of human services may conduct a pilot project evaluating the impact of engagement services in decreasing commitments, increasing engagement in treatment, and other measures.

Sec. 19. Minnesota Statutes 2024, section 253B.09, subdivision 3a, is amended to read:

Subd. 3a. **Reporting judicial commitments; private treatment program or facility.** Notwithstanding section 253B.23, subdivision 9, when a court commits a patient to a non-state-operated treatment facility or program, the court shall report the commitment to the commissioner through the supreme court information system for purposes of providing commitment information for firearm background checks under section 246C.15. If the patient is committed to a state-operated treatment program, the court shall send a copy of the commitment order to the commissioner ~~and the executive board~~.

Sec. 20. Minnesota Statutes 2024, section 253B.18, subdivision 6, is amended to read:

Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be transferred out of a secure treatment facility unless it appears to the satisfaction of the ~~executive board~~ commissioner, after a hearing and favorable recommendation by a majority of the special review board, that the transfer is appropriate. Transfer may be to another state-operated treatment program. In those instances where a commitment also exists to the Department of Corrections, transfer may be to a facility designated by the commissioner of corrections.

(b) The following factors must be considered in determining whether a transfer is appropriate:

(1) the person's clinical progress and present treatment needs;

(2) the need for security to accomplish continuing treatment;

(3) the need for continued institutionalization;

(4) which facility can best meet the person's needs; and

(5) whether transfer can be accomplished with a reasonable degree of safety for the public.

(c) If a committed person has been transferred out of a secure treatment facility pursuant to this subdivision, that committed person may voluntarily return to a secure treatment facility for a period of up to 60 days with the consent of the head of the treatment facility.

(d) If the committed person is not returned to the original, nonsecure transfer facility within 60 days of being readmitted to a secure treatment facility, the transfer is revoked and the committed person must remain in a secure treatment facility. The committed person must immediately be notified in writing of the revocation.

(e) Within 15 days of receiving notice of the revocation, the committed person may petition the special review board for a review of the revocation. The special review board shall review the circumstances of the revocation and shall recommend to the commissioner whether or not the revocation should be upheld. The special review board may also recommend a new transfer at the time of the revocation hearing.

(f) No action by the special review board is required if the transfer has not been revoked and the committed person is returned to the original, nonsecure transfer facility with no substantive change to the conditions of the transfer ordered under this subdivision.

(g) The head of the treatment facility may revoke a transfer made under this subdivision and require a committed person to return to a secure treatment facility if:

(1) remaining in a nonsecure setting does not provide a reasonable degree of safety to the committed person or others; or

(2) the committed person has regressed clinically and the facility to which the committed person was transferred does not meet the committed person's needs.

(h) Upon the revocation of the transfer, the committed person must be immediately returned to a secure treatment facility. A report documenting the reasons for revocation must be issued by the head of the treatment facility within seven days after the committed

person is returned to the secure treatment facility. Advance notice to the committed person of the revocation is not required.

(i) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report must be served upon the committed person, the committed person's counsel, and the designated agency. The report must outline the specific reasons for the revocation, including but not limited to the specific facts upon which the revocation is based.

(j) If a committed person's transfer is revoked, the committed person may re-petition for transfer according to subdivision 5.

(k) A committed person aggrieved by a transfer revocation decision may petition the special review board within seven business days after receipt of the revocation report for a review of the revocation. The matter must be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and, after considering the factors in paragraph (b), shall recommend to the commissioner whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure treatment facility at the time of the revocation hearing.

Sec. 21. Minnesota Statutes 2024, section 253B.19, subdivision 2, is amended to read:

Subd. 2. **Petition; hearing.** (a) A patient committed as a person who has a mental illness and is dangerous to the public under section 253B.18, or the county attorney of the county from which the patient was committed or the county of financial responsibility, may petition the judicial appeal panel for a rehearing and reconsideration of a decision by the commissioner under section 253B.18, subdivision 5. The judicial appeal panel must not consider petitions for relief other than those considered by the ~~executive board~~ commissioner from which the appeal is taken. The petition must be filed with the supreme court within 30 days after the decision of the ~~executive board~~ commissioner is signed. The hearing must be held within 45 days of the filing of the petition unless an extension is granted for good cause.

(b) For an appeal under paragraph (a), the supreme court shall refer the petition to the chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county attorney of the county of commitment, the designated agency, the ~~executive board~~ commissioner, the head of the facility or program to which the patient was committed, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing.

(c) Any person may oppose the petition. The patient, the patient's counsel, the county attorney of the committing county or the county of financial responsibility, and the ~~executive board~~ commissioner shall participate as parties to the proceeding pending before the judicial appeal panel and shall, except when the patient is committed solely as a person who has a mental illness and is dangerous to the public, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of their position. The judicial appeal panel may appoint court examiners and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all proceedings. The patient, the patient's counsel, and the county attorney of the committing county or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions. The petitioning party seeking discharge or provisional discharge bears the burden of going forward with the evidence, which means presenting a prima facie case with competent evidence to show that the person is entitled to the requested relief. If the petitioning party has met this burden, the party opposing discharge or provisional discharge bears the burden of proof by clear and convincing evidence that the discharge or provisional discharge should be denied. A party seeking transfer under section 253B.18, subdivision 6, must establish by a preponderance of the evidence that the transfer is appropriate.

Sec. 22. Minnesota Statutes 2024, section 253B.20, subdivision 2, is amended to read:

Subd. 2. **Necessities.** (a) The state-operated treatment program shall make necessary arrangements at the expense of the state to insure that no patient is discharged or provisionally discharged without suitable clothing. The head of the state-operated treatment program shall, if necessary, provide the patient with a sufficient sum of money to secure transportation home, or to another destination of the patient's choice, if the destination is located within a reasonable distance of the state-operated treatment program.

(b) The commissioner of human services shall establish procedures by rule to help the patient receive all public assistance benefits provided by state or federal law to which the patient is entitled by residence and circumstances. The rule shall be uniformly applied in all counties. All counties shall provide temporary relief whenever necessary to meet the intent of this subdivision.

(c) The commissioner of human services and the ~~executive board~~ commissioner may adopt joint rules necessary to accomplish the requirements under paragraph (b).

Sec. 23. Minnesota Statutes 2024, section 253D.02, is amended by adding a subdivision to read:

Subd. 2a. **Commissioner.** "Commissioner" means the commissioner of direct care and treatment.

Sec. 24. Minnesota Statutes 2024, section 253D.02, subdivision 3, is amended to read:

Subd. 3. **Commissioner of corrections.** "Commissioner of corrections" means the commissioner of corrections or the commissioner's designee.

Sec. 25. Minnesota Statutes 2024, section 254B.05, subdivision 4, is amended to read:

Subd. 4. **Regional treatment centers.** Regional treatment center substance use disorder treatment units are eligible vendors. The ~~executive board~~ commissioner of direct care and treatment may expand the capacity of substance use disorder treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for by funding under this chapter or other funding sources. Notwithstanding the provisions of sections 254B.03 to 254B.04, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the behavioral health fund, shall become the responsibility of the county.

Sec. 26. Minnesota Statutes 2024, section 256.045, is amended by adding a subdivision to read:

Subd. 1b. **Commissioner.** For purposes of this section, "commissioner" means the commissioner of human services.

Sec. 27. Minnesota Statutes 2024, section 256.045, subdivision 6, is amended to read:

Subd. 6. **Additional powers of commissioner; subpoenas.** (a) The commissioner of human services, the commissioner of health for matters within the commissioner's jurisdiction under subdivision 3b, or the ~~Direct Care and Treatment executive board~~ commissioner of direct care and treatment for matters within the commissioner's jurisdiction ~~of the executive board~~ under subdivision 5a, may initiate a review of any action or decision of a county agency and direct that the matter be presented to a state human services judge for a hearing held under subdivision 3, 3a, 3b, or 4a. In all matters dealing with human services committed by law to the discretion of the county agency, the judgment of the applicable commissioner

~~or executive board~~ may be substituted for that of the county agency. The applicable commissioner ~~or executive board~~ may order an independent examination when appropriate.

(b) Any party to a hearing held pursuant to subdivision 3, 3a, 3b, or 4a may request that the applicable commissioner ~~or executive board~~ issue a subpoena to compel the attendance of witnesses and the production of records at the hearing. A local agency may request that the applicable commissioner ~~or executive board~~ issue a subpoena to compel the release of information from third parties prior to a request for a hearing under section 256.046 upon a showing of relevance to such a proceeding. The issuance, service, and enforcement of subpoenas under this subdivision is governed by section 357.22 and the Minnesota Rules of Civil Procedure.

(c) The commissioner of human services may issue a temporary order staying a proposed demission by a residential facility licensed under chapter 245A:

(1) while an appeal by a recipient under subdivision 3 is pending;

(2) for the period of time necessary for the case management provider to implement the commissioner's order; or

(3) for appeals under subdivision 3, paragraph (a), clause (11), when the individual is seeking a temporary stay of demission on the basis that the county has not yet finalized an alternative arrangement for a residential facility, a program, or services that will meet the assessed needs of the individual by the effective date of the service termination, a temporary stay of demission may be issued for no more than 30 calendar days to allow for such arrangements to be finalized.

Sec. 28. Minnesota Statutes 2024, section 256.045, subdivision 7, is amended to read:

Subd. 7. **Judicial review.** Except for a prepaid health plan, any party who is aggrieved by an order of the commissioner of human services; the commissioner of health; or the commissioner of children, youth, and families in appeals within the commissioner's jurisdiction under subdivision 3b; or the ~~Direct Care and Treatment executive board~~ commissioner of direct care and treatment in appeals within the commissioner's jurisdiction ~~of the executive board~~ under subdivision 5a may appeal the order to the district court of the county responsible for furnishing assistance, or, in appeals under subdivision 3b, the county where the maltreatment occurred, by serving a written copy of a notice of appeal upon the applicable commissioner ~~or executive board~~ and any adverse party of record within 30 days after the date the commissioner ~~or executive board~~ issued the order, the amended order, or order affirming the original order, and by filing the original notice and proof of service with

the court administrator of the district court. Service may be made personally or by mail; service by mail is complete upon mailing; no filing fee shall be required by the court administrator in appeals taken pursuant to this subdivision, with the exception of appeals taken under subdivision 3b. The applicable commissioner ~~or executive board~~ may elect to become a party to the proceedings in the district court. Except for appeals under subdivision 3b, any party may demand that the applicable commissioner ~~or executive board~~ furnish all parties to the proceedings with a copy of the decision, and a transcript of any testimony, evidence, or other supporting papers from the hearing held before the human services judge, by serving a written demand upon the applicable commissioner ~~or executive board~~ within 30 days after service of the notice of appeal. Any party aggrieved by the failure of an adverse party to obey an order issued by the applicable commissioner ~~or executive board~~ under subdivision 5 or 5a may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

Sec. 29. Minnesota Statutes 2024, section 256G.09, subdivision 3, is amended to read:

Subd. 3. **Commissioner obligations.** (a) Except as provided in paragraph (b) for matters under the jurisdiction of the ~~Direct Care and Treatment executive board~~ commissioner of direct care and treatment, the commissioner shall then promptly decide any question of financial responsibility as outlined in this chapter and make an order referring the application to the local agency of the proper county for further action. Further action may include reimbursement by that county of assistance that another county has provided to the applicant under this subdivision. The commissioner shall decide disputes within 60 days of the last county evidentiary submission and shall issue an immediate opinion.

(b) For disputes regarding financial responsibility relating to matters under the jurisdiction of the ~~direct care and treatment executive board~~ commissioner of direct care and treatment, the commissioner shall promptly issue an advisory opinion on any question of financial responsibility as outlined in this chapter and recommend to the ~~executive board~~ commissioner of direct care and treatment an order referring the application to the local agency of the proper county for further action. Further action may include reimbursement by that county of assistance that another county has provided to the applicant under this subdivision. The commissioner shall provide an advisory opinion and recommended order to the ~~executive board~~ commissioner of direct care and treatment within 30 days of the last county evidentiary submission. The ~~executive board~~ commissioner of direct care and treatment shall decide to accept or reject the commissioner's advisory opinion and recommended order within 60 days of the last county evidentiary submission and shall issue an immediate opinion stating the reasons for accepting or rejecting the commissioner's recommendation.

(c) The commissioner may make any investigation ~~it~~ the commissioner considers proper before making a decision or a recommendation to the ~~executive board~~ commissioner of direct care and treatment. The commissioner may prescribe rules ~~it~~ the commissioner considers necessary to carry out this subdivision except that the commissioner must not create rules purporting to bind the ~~executive board's~~ decision of the commissioner of direct care and treatment on any advisory opinion or recommended order under paragraph (b).

(d) Except as provided in paragraph (e) for matters under the jurisdiction of the ~~executive board~~ commissioner of direct care and treatment, the order of the commissioner binds the local agency involved and the applicant or recipient. That agency shall comply with the order unless reversed on appeal as provided in section 256.045, subdivision 7. The agency shall comply with the order pending the appeal.

(e) For disputes regarding financial responsibility relating to matters under the jurisdiction of the ~~Direct Care and Treatment executive board~~ commissioner of direct care and treatment, the order of the ~~executive board~~ commissioner of direct care and treatment binds the local agency involved and the applicant or recipient. That agency shall comply with the order of the ~~executive board~~ commissioner of direct care and treatment unless the order is reversed on appeal as provided in section 256.045, subdivision 7. The agency shall comply with the order of the ~~executive board~~ commissioner of direct care and treatment pending the appeal.

Sec. 30. Minnesota Statutes 2024, section 352.91, subdivision 2a, is amended to read:

Subd. 2a. **Special teachers.** "Covered correctional service" also means service rendered by a state employee as a special teacher employed by the Department of Corrections or by the Department of Direct Care and Treatment at a security unit, provided that at least 75 percent of the employee's working time is spent in direct contact with inmates or patients and the fact of this direct contact is certified to the executive director by the appropriate commissioner ~~or executive board~~, unless the person elects to retain the current retirement coverage under Laws 1996, chapter 408, article 8, section 21.

Sec. 31. Minnesota Statutes 2024, section 352.91, subdivision 3c, is amended to read:

Subd. 3c. **Nursing personnel.** (a) "Covered correctional service" means service by a state employee in one of the employment positions at a correctional facility, in the state-operated forensic services program, or in the Minnesota Sex Offender Program that are specified in paragraph (b) if at least 75 percent of the employee's working time is spent in direct contact with inmates or patients and the fact of this direct contact is certified to the executive director by the appropriate commissioner ~~or executive board~~.

(b) The employment positions are as follows:

(1) registered nurse - senior;

(2) registered nurse;

(3) registered nurse - principal;

(4) licensed practical nurse;

(5) registered nurse advance practice; and

(6) psychiatric advance practice registered nurse.

Sec. 32. Minnesota Statutes 2024, section 352.91, subdivision 3d, is amended to read:

Subd. 3d. **Other correctional personnel.** (a) "Covered correctional service" means service by a state employee in one of the employment positions at a correctional facility or in the state-operated forensic services program specified in paragraph (b) if at least 75 percent of the employee's working time is spent in direct contact with inmates or patients and the fact of this direct contact is certified to the executive director by the appropriate commissioner ~~or executive board~~.

(b) The employment positions are:

(1) automotive mechanic;

(2) baker;

(3) central services administrative specialist, intermediate;

(4) central services administrative specialist, principal;

(5) chaplain;

(6) chief cook;

(7) clinical program therapist 1;

(8) clinical program therapist 2;

(9) clinical program therapist 3;

(10) clinical program therapist 4;

(11) cook;

(12) cook coordinator;

(13) corrections inmate program coordinator;

(14) corrections transitions program coordinator;

(15) corrections security caseworker;

(16) corrections security caseworker career;

(17) corrections teaching assistant;

(18) delivery van driver;

(19) dentist;

(20) electrician supervisor;

(21) general maintenance worker lead;

(22) general repair worker;

(23) library/information research services specialist;

(24) library/information research services specialist senior;

(25) library technician;

(26) painter lead;

(27) plant maintenance engineer lead;

(28) plumber supervisor;

(29) psychologist 1;

(30) psychologist 3;

(31) recreation therapist;

(32) recreation therapist coordinator;

(33) recreation program assistant;

(34) recreation therapist senior;

(35) sports medicine specialist;

(36) work therapy assistant;

(37) work therapy program coordinator; and

(38) work therapy technician.

Sec. 33. Minnesota Statutes 2024, section 352.91, subdivision 4a, is amended to read:

Subd. 4a. **Process for evaluating and recommending potential employment positions for membership inclusion.** (a) The Department of Corrections and the Department of Direct Care and Treatment must establish a procedure for evaluating periodic requests by department ~~and agency~~ employees for qualification for recommendation by the applicable commissioner ~~or executive board~~ for inclusion of the employment position in the correctional facility or direct care and treatment facility in the correctional retirement plan and for periodically determining employment positions that no longer qualify for continued correctional retirement plan coverage.

(b) The procedure must provide for an evaluation of the extent of the employee's working time spent in direct contact with patients or inmates, the extent of the physical hazard that the employee is routinely subjected to in the course of employment, and the extent of intervention routinely expected of the employee in the event of a facility incident. The percentage of routine direct contact with inmates or patients may not be less than 75 percent.

(c) The applicable commissioner ~~or executive board~~ shall notify the employee of the determination of the appropriateness of recommending the employment position for inclusion in the correctional retirement plan, if the evaluation procedure results in a finding that the employee:

(1) routinely spends 75 percent of the employee's time in direct contact with inmates or patients; and

(2) is regularly engaged in the rehabilitation, treatment, custody, or supervision of inmates or patients.

(d) After providing the affected employee an opportunity to dispute or clarify any evaluation determinations, if the applicable commissioner ~~or executive board~~ determines that the employment position is appropriate for inclusion in the correctional retirement plan, the commissioner ~~or executive board~~ shall forward that recommendation and supporting documentation to the chair of the Legislative Commission on Pensions and Retirement, the chair of the State and Local Governmental Operations Committee of the senate, the chair of the Governmental Operations and Veterans Affairs Policy Committee of the house of representatives, and the executive director of the Legislative Commission on Pensions and Retirement in the form of the appropriate proposed legislation. The recommendation must be forwarded to the legislature before January 15 for the recommendation to be considered in that year's legislative session.

Sec. 34. Minnesota Statutes 2024, section 524.3-801, is amended to read:

524.3-801 NOTICE TO CREDITORS.

(a) Unless notice has already been given under this section, upon appointment of a general personal representative in informal proceedings or upon the filing of a petition for formal appointment of a general personal representative, notice thereof, in the form prescribed by court rule, shall be given under the direction of the court administrator by publication once a week for two successive weeks in a legal newspaper in the county wherein the proceedings are pending giving the name and address of the general personal representative and notifying creditors of the estate to present their claims within four months after the date of the court administrator's notice which is subsequently published or be forever barred, unless they are entitled to further service of notice under paragraph (b) or (c).

(b) The personal representative shall, within three months after the date of the first publication of the notice, serve a copy of the notice upon each then known and identified creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, notice to the commissioner of human services or ~~Direct Care and Treatment executive board~~ the commissioner of direct care and treatment, as applicable, must be given under paragraph (d) instead of under this paragraph or paragraph (c). A creditor is "known" if: (i) the personal representative knows that the creditor has asserted a claim that arose during the decedent's life against either the decedent or the decedent's estate; (ii) the creditor has asserted a claim that arose during the decedent's life and the fact is clearly disclosed in accessible financial records known and available to the personal representative; or (iii) the claim of the creditor would be revealed by a reasonably diligent search for creditors of the decedent in accessible financial records known and available to the personal representative. Under this section, a creditor is "identified" if the personal representative's knowledge of the name and address of the creditor will permit service of notice to be made under paragraph (c).

(c) Unless the claim has already been presented to the personal representative or paid, the personal representative shall serve a copy of the notice required by paragraph (b) upon each creditor of the decedent who is then known to the personal representative and identified either by delivery of a copy of the required notice to the creditor, or by mailing a copy of the notice to the creditor by certified, registered, or ordinary first class mail addressed to the creditor at the creditor's office or place of residence.

(d)(1) Effective for decedents dying on or after July 1, 1997, if the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative or the attorney for the personal representative shall serve the commissioner of human services or ~~executive board~~ the commissioner of direct care and treatment, as applicable, with notice in the manner prescribed in paragraph (c), or electronically in a manner prescribed by the applicable commissioner ~~or executive board~~, as soon as practicable after the appointment of the personal representative. The notice must state the decedent's full name, date of birth, and Social Security number and, to the extent then known after making a reasonably diligent inquiry, the full name, date of birth, and Social Security number for each of the decedent's predeceased spouses. The notice may also contain a statement that, after making a reasonably diligent inquiry, the personal representative has determined that the decedent did not have any predeceased spouses or that the personal representative has been unable to determine one or more of the previous items of information for a predeceased spouse of the decedent. A copy of the notice to creditors must be attached to and be a part of the notice to the applicable commissioner ~~or executive board~~.

(2) Notwithstanding a will or other instrument or law to the contrary, except as allowed in this paragraph, no property subject to administration by the estate may be distributed by the estate or the personal representative until 70 days after the date the notice is served on the commissioner of human services or ~~executive board~~ commissioner of direct care and treatment as provided in paragraph (c), unless the local agency consents as provided for in clause (6). This restriction on distribution does not apply to the personal representative's sale of real or personal property, but does apply to the net proceeds the estate receives from these sales. The personal representative, or any person with personal knowledge of the facts, may provide an affidavit containing the description of any real or personal property affected by this paragraph and stating facts showing compliance with this paragraph. If the affidavit describes real property, it may be filed or recorded in the office of the county recorder or registrar of titles for the county where the real property is located. This paragraph does not apply to proceedings under sections 524.3-1203 and 525.31, or when a duly authorized agent of a county is acting as the personal representative of the estate.

(3) At any time before an order or decree is entered under section 524.3-1001 or 524.3-1002, or a closing statement is filed under section 524.3-1003, the personal representative or the attorney for the personal representative may serve an amended notice on the commissioner of human services or ~~executive board~~ commissioner of direct care and treatment to add variations or other names of the decedent or a predeceased spouse named

in the notice, the name of a predeceased spouse omitted from the notice, to add or correct the date of birth or Social Security number of a decedent or predeceased spouse named in the notice, or to correct any other deficiency in a prior notice. The amended notice must state the decedent's name, date of birth, and Social Security number, the case name, case number, and district court in which the estate is pending, and the date the notice being amended was served on the applicable commissioner ~~or executive board~~. If the amendment adds the name of a predeceased spouse omitted from the notice, it must also state that spouse's full name, date of birth, and Social Security number. The amended notice must be served on the applicable commissioner ~~or executive board~~ in the same manner as the original notice. Upon service, the amended notice relates back to and is effective from the date the notice it amends was served, and the time for filing claims arising under section 246.53, 256B.15, 256D.16 or 261.04 is extended by 60 days from the date of service of the amended notice. Claims filed during the 60-day period are undischarged and unbarred claims, may be prosecuted by the entities entitled to file those claims in accordance with section 524.3-1004, and the limitations in section 524.3-1006 do not apply. The personal representative or any person with personal knowledge of the facts may provide and file or record an affidavit in the same manner as provided for in clause (1).

(4) Within one year after the date an order or decree is entered under section 524.3-1001 or 524.3-1002 or a closing statement is filed under section 524.3-1003, any person who has an interest in property that was subject to administration by the estate may serve an amended notice on the commissioner of human services or ~~executive board~~ commissioner of direct care and treatment to add variations or other names of the decedent or a predeceased spouse named in the notice, the name of a predeceased spouse omitted from the notice, to add or correct the date of birth or Social Security number of a decedent or predeceased spouse named in the notice, or to correct any other deficiency in a prior notice. The amended notice must be served on the applicable commissioner ~~or executive board~~ in the same manner as the original notice and must contain the information required for amendments under clause (3). If the amendment adds the name of a predeceased spouse omitted from the notice, it must also state that spouse's full name, date of birth, and Social Security number. Upon service, the amended notice relates back to and is effective from the date the notice it amends was served. If the amended notice adds the name of an omitted predeceased spouse or adds or corrects the Social Security number or date of birth of the decedent or a predeceased spouse already named in the notice, then, notwithstanding any other laws to the contrary, claims against the decedent's estate on account of those persons resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or 261.04 are undischarged and unbarred claims, may be prosecuted by the entities entitled to file those claims in accordance

with section 524.3-1004, and the limitations in section 524.3-1006 do not apply. The person filing the amendment or any other person with personal knowledge of the facts may provide and file or record an affidavit describing affected real or personal property in the same manner as clause (1).

(5) After one year from the date an order or decree is entered under section 524.3-1001 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission, or defect of any kind in the notice to the commissioner of human services or ~~executive board~~ commissioner of direct care and treatment required under this paragraph or in the process of service of the notice on the applicable commissioner ~~or executive board~~, or the failure to serve the applicable commissioner ~~or executive board~~ with notice as required by this paragraph, makes any distribution of property by a personal representative void or voidable. The distributee's title to the distributed property shall be free of any claims based upon a failure to comply with this paragraph.

(6) The local agency may consent to a personal representative's request to distribute property subject to administration by the estate to distributees during the 70-day period after service of notice on the applicable commissioner ~~or executive board~~. The local agency may grant or deny the request in whole or in part and may attach conditions to its consent as it deems appropriate. When the local agency consents to a distribution, it shall give the estate a written certificate evidencing its consent to the early distribution of assets at no cost. The certificate must include the name, case number, and district court in which the estate is pending, the name of the local agency, describe the specific real or personal property to which the consent applies, state that the local agency consents to the distribution of the specific property described in the consent during the 70-day period following service of the notice on the applicable commissioner ~~or executive board~~, state that the consent is unconditional or list all of the terms and conditions of the consent, be dated, and may include other contents as may be appropriate. The certificate must be signed by the director of the local agency or the director's designees and is effective as of the date it is dated unless it provides otherwise. The signature of the director or the director's designee does not require any acknowledgment. The certificate shall be prima facie evidence of the facts it states, may be attached to or combined with a deed or any other instrument of conveyance and, when so attached or combined, shall constitute a single instrument. If the certificate describes real property, it shall be accepted for recording or filing by the county recorder or registrar of titles in the county in which the property is located. If the certificate describes real property and is not attached to or combined with a deed or other instrument of conveyance, it shall be accepted for recording or filing by the county recorder or registrar of titles in the county

in which the property is located. The certificate constitutes a waiver of the 70-day period provided for in clause (2) with respect to the property it describes and is prima facie evidence of service of notice on the applicable commissioner ~~or executive board~~. The certificate is not a waiver or relinquishment of any claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and does not otherwise constitute a waiver of any of the personal representative's duties under this paragraph. Distributees who receive property pursuant to a consent to an early distribution shall remain liable to creditors of the estate as provided for by law.

(7) All affidavits provided for under this paragraph:

(i) shall be provided by persons who have personal knowledge of the facts stated in the affidavit;

(ii) may be filed or recorded in the office of the county recorder or registrar of titles in the county in which the real property they describe is located for the purpose of establishing compliance with the requirements of this paragraph; and

(iii) are prima facie evidence of the facts stated in the affidavit.

(8) This paragraph applies to the estates of decedents dying on or after July 1, 1997. Clause (5) also applies with respect to all notices served on the commissioner of human services before July 1, 1997, under Laws 1996, chapter 451, article 2, section 55. All notices served on the commissioner of human services before July 1, 1997, pursuant to Laws 1996, chapter 451, article 2, section 55, shall be deemed to be legally sufficient for the purposes for which they were intended, notwithstanding any errors, omissions or other defects.

Sec. 35. Minnesota Statutes 2024, section 611.57, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The Certification Advisory Committee consists of the following members:

(1) a mental health professional, as defined in section 245I.02, subdivision 27, with community behavioral health experience, appointed by the governor;

(2) a board-certified forensic psychiatrist with experience in competency evaluations, providing competency attainment services, or both, appointed by the governor;

(3) a board-certified forensic psychologist with experience in competency evaluations, providing competency attainment services, or both, appointed by the governor;

(4) the president of the Minnesota Corrections Association or a designee;

(5) the ~~direct care and treatment deputy commissioner~~ chief executive officer of direct care and treatment or a designee;

(6) the president of the Minnesota Association of County Social Service Administrators or a designee;

(7) the president of the Minnesota Association of Community Mental Health Providers or a designee;

(8) the president of the Minnesota Sheriffs' Association or a designee; and

(9) the executive director of the National Alliance on Mental Illness Minnesota or a designee.

(b) Members of the advisory committee serve without compensation and at the pleasure of the appointing authority. Vacancies shall be filled by the appointing authority consistent with the qualifications of the vacating member required by this subdivision.

Sec. 36. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber each provision of Minnesota Statutes listed in column A to the number listed in column B.

Column A	Column B
246B.01, subdivision 2b	246B.01, subdivision 2f
246B.01, subdivision 2c	246B.01, subdivision 2g
246B.01, subdivision 2d	246B.01, subdivision 2h

Sec. 37. **REPEALER.**

Minnesota Statutes 2024, sections 246B.01, subdivision 2; 252.021, subdivision 2; 253.195, subdivision 2; 253B.02, subdivision 7b; 253D.02, subdivision 7a; 254B.01, subdivision 15; 256.045, subdivision 1a; and 256G.02, subdivision 5a, are repealed.

Sec. 38. **EFFECTIVE DATE.**

This article is effective the day following final enactment.

ARTICLE 10
DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2024, section 144A.01, subdivision 4, is amended to read:

Subd. 4. **Controlling person.** (a) "Controlling person" means an owner and the following individuals and entities, if applicable:

(1) each officer of the organization, including the chief executive officer and the chief financial officer;

(2) the nursing home administrator; ~~and~~

(3) any managerial official~~.~~; and

(4) if no individual has at least a five percent ownership interest, every individual with an ownership interest in a privately held corporation, limited liability company, or other business entity, including a business entity that is publicly traded or nonpublicly traded, that collects capital investments from individuals or entities.

(b) "Controlling person" also means any entity or natural person who has any direct or indirect ownership interest in:

(1) any corporation, partnership or other business association which is a controlling person;

(2) the land on which a nursing home is located;

(3) the structure in which a nursing home is located;

(4) any entity with at least a five percent mortgage, contract for deed, deed of trust, or other security interest in the land or structure comprising a nursing home; or

(5) any lease or sublease of the land, structure, or facilities comprising a nursing home.

(c) "Controlling person" does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly or through a subsidiary operates a nursing home;

(2) government and government-sponsored entities such as the United States Department of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota Housing Finance Agency which provide loans, financing, and insurance products for housing sites;

(3) an individual who is a state or federal official, a state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more nursing homes, unless the individual is also an officer, owner, or managerial official of the nursing home, receives any remuneration from a nursing home, or who is a controlling person not otherwise excluded in this subdivision;

(4) a natural person who is a member of a tax-exempt organization under section 290.05, subdivision 2, unless the individual is also a controlling person not otherwise excluded in this subdivision; and

(5) a natural person who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt by virtue of section 80A.45, clause (6); or

(ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

Sec. 2. Minnesota Statutes 2024, section 144A.474, subdivision 11, is amended to read:

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (b) and imposed immediately with no opportunity to correct the violation first as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, a fine of $500 per violation, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, a fine of $3,000 per incident, in addition to any of the enforcement mechanisms authorized in section 144A.475;

(4) Level 4, a fine of $5,000 per incident, in addition to any of the enforcement mechanisms authorized in section 144A.475;

(5) for maltreatment violations for which the licensee was determined to be responsible for the maltreatment under section 626.557, subdivision 9c, paragraph (c), a fine of $1,000. A fine of $5,000 may be imposed if the commissioner determines the licensee is responsible for maltreatment consisting of sexual assault, death, or abuse resulting in serious injury; and

(6) the fines in clauses (1) to (4) are increased and immediate fine imposition is authorized for both surveys and investigations conducted.

When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death;

(2) scope of violation:

(i) isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner shall provide a notice of noncompliance with a correction order by email to the applicant's or provider's last known email address. The noncompliance notice must list the violations not corrected.

(d) For every violation identified by the commissioner, the commissioner shall issue an immediate fine pursuant to paragraph (a), clause (6). The license holder must still correct the violation in the time specified. The issuance of an immediate fine can occur in addition to any enforcement mechanism authorized under section 144A.475. The immediate fine may be appealed as allowed under this subdivision.

(e) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(f) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(g) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

(h) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(i) In addition to any fine imposed under this section, the commissioner may assess a penalty amount based on costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(j) Fines collected under paragraph (a), clauses (1) to (4), shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799. The commissioner must publish on the department's website an annual report on the fines assessed and collected, and how the appropriated money was allocated.

~~(k) Fines collected under paragraph (a), clause (5), shall be deposited in a dedicated special revenue account and appropriated to the commissioner to provide compensation according to subdivision 14 to clients subject to maltreatment. A client may choose to receive compensation from this fund, not to exceed $5,000 for each substantiated finding of maltreatment, or take civil action. This paragraph expires July 31, 2021.~~

Sec. 3. Minnesota Statutes 2024, section 144A.4799, is amended to read:

144A.4799 ~~DEPARTMENT OF HEALTH LICENSED~~ HOME CARE ~~PROVIDER~~ AND ASSISTED LIVING ADVISORY COUNCIL.

Subdivision 1. **Membership.** The commissioner of health shall appoint ~~13~~ 14 persons to a home care and assisted living ~~program~~ advisory council consisting of the following:

(1) ~~two~~ four public members as defined in section 214.02 ~~who shall be persons who are currently receiving home care services, persons who have received home care services within five years of the application date, persons who have family members receiving home~~

~~care services, or persons who have family members who have received home care services within five years of the application date~~, one of whom must be a person who either is receiving or has received home care services preferably within the five years prior to initial appointment, one of whom must be a person who has or had a family member receiving home care services preferably within the five years prior to initial appointment, one of whom must be a person who either is or has been a resident in an assisted living facility preferably within the five years prior to initial appointment, and one of whom must be a person who has or had a family member residing in an assisted living facility preferably within the five years prior to initial appointment;

(2) two Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing;

(4) one member representing the Office of Ombudsman for Long-Term Care;

(5) one member representing the Office of Ombudsman for Mental Health and Developmental Disabilities;

(6) ~~beginning July 1, 2021,~~ one member of a county health and human services or county adult protection office;

(7) two Minnesota assisted living facility licensees representing assisted living facilities and assisted living facilities with dementia care levels of licensure who may be the facility's assisted living director, managerial official, or clinical nurse supervisor;

(8) one organization representing long-term care providers, home care providers, and assisted living providers in Minnesota; and

(9) ~~two public members as defined in section 214.02. One public member shall be a person who either is or has been a resident in an assisted living facility and one public member shall be a person who has or had a family member living in an assisted living facility setting~~ one representative of a consumer advocacy organization representing individuals receiving long-term care from licensed home care or assisted living providers.

Subd. 2. **Organizations and meetings.** The advisory council shall be organized and administered under section 15.059 with per diems and costs paid within the limits of available appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees may be developed as necessary by the commissioner. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed assisted living and home care providers in this chapter and chapter 144G, including advice on the following:

(1) community standards for home care practices;

(2) enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) ways of distributing information to licensees and consumers of .home care and assisted living services defined under chapter 144G;

(4) training standards;

(5) identifying emerging issues and opportunities in home care and assisted living services defined under chapter 144G;

(6) identifying the use of technology in home and telehealth capabilities;

(7) allowable home care licensing modifications and exemptions, including a method for an integrated license with an existing license for rural licensed nursing homes to provide limited home care services in an adjacent independent living apartment building owned by the licensed nursing home; and

(8) recommendations for studies using the data in section 62U.04, subdivision 4, including but not limited to studies concerning costs related to dementia and chronic disease among an elderly population over 60 and additional long-term care costs~~, as described in section 62U.10, subdivision 6~~.

(b) The advisory council shall perform other duties as directed by the commissioner.

(c) The advisory council shall ~~annually~~ make recommendations annually to the commissioner for the purposes of allocating the appropriation in ~~section~~ sections 144A.474, subdivision 11, paragraph ~~(i)~~ (j), and 144G.31, subdivision 8. The commissioner shall act upon the recommendations of the advisory council within one year of the advisory council submitting its recommendations to the commissioner. The recommendations shall address ways the commissioner may improve protection of the public under existing statutes and laws and improve quality of care. The council's recommendations may include but are not limited to special projects or initiatives that:

(1) create and administer training of licensees and ongoing training for their employees to improve clients' and residents' lives, ~~supporting ways that~~ support licensees, ~~can~~ improve

and enhance quality care, and ~~ways to~~ provide technical assistance to licensees to improve compliance;

(2) develop and implement information technology and data projects that analyze and communicate information about trends ~~of~~ in violations or lead to ways of improving resident and client care;

(3) improve communications strategies to licensees and the public;

(4) recruit and retain direct care staff;

(5) recommend education related to the care of vulnerable adults in professional nursing programs, nurse aide programs, and home health aide programs; and

(6) ~~other projects or pilots that~~ benefit residents, clients, families, and the public in other ways.

EFFECTIVE DATE. This section is effective July 1, 2025, and the amendments to subdivision 1, clause (1), apply to members whose initial appointment occurs on or after that date.

Sec. 4. Minnesota Statutes 2024, section 144G.08, subdivision 15, is amended to read:

Subd. 15. **Controlling individual.** (a) "Controlling individual" means an owner and the following individuals and entities, if applicable:

(1) each officer of the organization, including the chief executive officer and chief financial officer;

(2) each managerial official; ~~and~~

(3) any entity with at least a five percent mortgage, deed of trust, or other security interest in the facility~~.~~; and

(4) if no individual has at least a five percent ownership interest, every individual with an ownership interest in a privately held corporation, limited liability company, or other business entity, including a business entity that is publicly traded or nonpublicly traded, that collects capital investments from individuals or entities.

(b) Controlling individual also means any entity or natural person who has any direct or indirect ownership interest in:

(1) any corporation, partnership, or other business association such as a limited liability company that is a controlling individual;

(2) the land on which an assisted living facility is located; or

(3) the structure in which an assisted living facility is located.

~~(b)~~ (c) Controlling individual does not include:

(1) a bank, savings bank, trust company, savings association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity operates a program directly or through a subsidiary;

(2) government and government-sponsored entities such as the U.S. Department of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota Housing Finance Agency which provide loans, financing, and insurance products for housing sites;

(3) an individual who is a state or federal official, a state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more facilities, unless the individual is also an officer, owner, or managerial official of the facility, receives remuneration from the facility, or owns any of the beneficial interests not excluded in this subdivision;

(4) an individual who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt under section 80A.45, clause (6); or

(ii) whose transactions are exempt under section 80A.46, clause (2);

(5) an individual who is a member of an organization exempt from taxation under section 290.05, unless the individual is also an officer, owner, or managerial official of the license or owns any of the beneficial interests not excluded in this subdivision. This clause does not exclude from the definition of controlling individual an organization that is exempt from taxation; or

(6) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual.

Sec. 5. Minnesota Statutes 2024, section 144G.31, subdivision 8, is amended to read:

Subd. 8. **Deposit of fines.** (a) Fines collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to a competitive grant program for assisted living providers licensed under chapter 144G or other organizations with experience in assisted living operations, compliance, and best practices for the purpose of the commissioner for special

projects to improve resident quality of care and outcomes in assisted living facilities licensed under this chapter in Minnesota. A provider with a provisional license under chapter 144G is not eligible to apply. The balance in the special revenue account as of January 1, 2026, must be appropriated for grants within two years, provided there are enough grant requests totaling the sum in the account. Thereafter, money in the special revenue account must be appropriated annually as recommended by the advisory council established in section 144A.4799, or as recommended by the commissioner after the advisory council's review and approval. The minimum amount of a grant award is $10,000. The commissioner may retain up to ten percent of the amount available to cover costs to administer the grants under this section.

(b) The commissioner must publish on the department's website an annual report on the fines assessed and collected, and how the appropriated money was allocated.

Sec. 6. Minnesota Statutes 2024, section 144G.52, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of sections 144G.52 to 144G.55, "termination" means:

(1) a facility-initiated termination of ~~housing provided to the resident under the contract~~ an assisted living contract; or

(2) a facility-initiated termination ~~or nonrenewal~~ of all assisted living services the resident receives from the facility under the assisted living contract.

Sec. 7. Minnesota Statutes 2024, section 144G.52, subdivision 2, is amended to read:

Subd. 2. **Prerequisite to termination of a contract.** (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to:

(1) explain in detail the reasons for the proposed termination; and

(2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility.

(b) For a termination pursuant to subdivision 3 or 4, the meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting.

(c) For a termination pursuant to subdivision 5, the meeting must be scheduled to take place at least five days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting.

(d) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting.

~~(d)~~ (e) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659.

Sec. 8. Minnesota Statutes 2024, section 144G.52, subdivision 3, is amended to read:

Subd. 3. **Termination for nonpayment.** (a) A facility may initiate a termination of housing because of nonpayment of rent or a termination of services because of nonpayment for services. Upon issuance of a notice of termination for nonpayment, the facility must inform the resident that public benefits may be available and must provide contact information for the Senior LinkAge Line under section 256.975, subdivision 7, or the Disability Hub under section 256.01, subdivision 24.

(b) An interruption to a resident's public benefits that lasts for no more than 60 days does not constitute nonpayment.

Sec. 9. Minnesota Statutes 2024, section 144G.52, subdivision 8, is amended to read:

Subd. 8. **Content of notice of termination.** The notice required under subdivision 7 must contain, at a minimum:

(1) the effective date of the termination of the assisted living contract;

(2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale;

(3) a detailed explanation of the conditions under which a new or amended contract may be executed;

(4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted;

(5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55;

(6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination;

(7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination;

(8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, or the Disability Hub under section 256.01, subdivision 24, and an explanation that the Senior LinkAge Line and the Disability Hub may provide information about other available housing or service options; and

(9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.

Sec. 10. Minnesota Statutes 2024, section 144G.54, subdivision 3, is amended to read:

Subd. 3. **Appeals process.** (a) The Office of Administrative Hearings must conduct an expedited hearing as soon as practicable under this section, but in no event later than 14 calendar days after the office receives the request, unless the parties agree otherwise or the chief administrative law judge deems the timing to be unreasonable, given the complexity of the issues presented. For terminations initiated pursuant to section 144G.52, subdivision 5, the Office of Administrative Hearings must conduct an expedited hearing as soon as practicable but in no event later than ten calendar days after the office receives the request, unless the parties agree otherwise. The Office of Administrative Hearings has discretion to order a continuance.

(b) The hearing must be held at the facility where the resident lives, unless holding the hearing at that location is impractical, the parties agree to hold the hearing at a different location, or the chief administrative law judge grants a party's request to appear at another location or by telephone or interactive video.

(c) The hearing is not a formal contested case proceeding, except when determined necessary by the chief administrative law judge.

(d) Parties may but are not required to be represented by counsel. The appearance of a party without counsel does not constitute the unauthorized practice of law.

(e) The hearing shall be limited to the amount of time necessary for the participants to expeditiously present the facts about the proposed termination. The administrative law judge shall issue a recommendation to the commissioner as soon as practicable, but in no event later than ten business days after the hearing related to a termination issued under section 144G.52, subdivision 3 or 4, or five business days for a hearing related to a termination issued under section 144G.52, subdivision 5.

Sec. 11. Minnesota Statutes 2024, section 144G.54, subdivision 7, is amended to read:

Subd. 7. **Application of chapter 504B to appeals of terminations.** A resident may not bring an action under chapter 504B to challenge a termination that has occurred and been upheld under this section. A facility is entitled to a writ of recovery of premises and order to vacate pursuant to section 504B.361 when a termination has been upheld under this section and the facility has met its obligation under section 144G.55.

Sec. 12. Minnesota Statutes 2024, section 144G.55, subdivision 1, is amended to read:

Subdivision 1. **Duties of facility.** (a) If a facility terminates an assisted living contract, reduces services to the extent that a resident needs to move or obtain a new service provider or the facility has its license restricted under section 144G.20, or the facility conducts a planned closure under section 144G.57, the facility:

(1) must ensure, subject to paragraph (c), a coordinated move to a safe location that is appropriate for the resident and that is identified by the facility prior to any hearing under section 144G.54 and document the same;

(2) must ensure a coordinated move of the resident to an appropriate service provider identified by the facility prior to any hearing under section 144G.54, provided services are still needed and desired by the resident; and

(3) must consult and cooperate with the resident, legal representative, designated representative, case manager for a resident who receives home and community-based waiver services under chapter 256S and section 256B.49, relevant health professionals, and any other persons of the resident's choosing to make arrangements to move the resident, including consideration of the resident's goals and document the same.

(b) A facility may satisfy the requirements of paragraph (a), clauses (1) and (2), by moving the resident to a different location within the same facility, if appropriate for the resident.

(c) A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies, and may choose instead to move to a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the termination notice.

(d) A facility has met its obligations under this section, following a termination completed in accordance with section 144G.52 if:

(1) for residents of facilities in the seven-county metropolitan area, the facility identifies at least three other facilities willing and able to meet the individual's service needs, one of which is within the seven-county metropolitan area;

(2) for residents of facilities outside of the seven-county metropolitan area, the facility identifies at least two other facilities willing and able to meet the individual's service needs, and to the extent such facilities exist, one must be within two hours or 120 miles from the resident's current location; and

(3) the facility documents, in writing, the resident or the resident's designated representative has:

(i) consented to move; or

(ii) expressly refused to relocate to any of the facilities identified in accordance with this subdivision.

(e) Sixty days before the facility plans to reduce or eliminate one or more services for a particular resident, the facility must provide written notice of the reduction that includes:

(1) a detailed explanation of the reasons for the reduction and the date of the reduction;

(2) the contact information for the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the name and contact

information of the person employed by the facility with whom the resident may discuss the reduction of services;

(3) a statement that if the services being reduced are still needed by the resident, the resident may remain in the facility and seek services from another provider; and

(4) a statement that if the reduction makes the resident need to move, the facility must participate in a coordinated move of the resident to another provider or caregiver, as required under this section.

~~(e)~~ (f) In the event of an unanticipated reduction in services caused by extraordinary circumstances, the facility must provide the notice required under paragraph ~~(d)~~ (e) as soon as possible.

~~(f)~~ (g) If the facility, a resident, a legal representative, or a designated representative determines that a reduction in services will make a resident need to move to a new location, the facility must ensure a coordinated move in accordance with this section, and must provide notice to the Office of Ombudsman for Long-Term Care.

~~(g)~~ (h) Nothing in this section affects a resident's right to remain in the facility and seek services from another provider.

Sec. 13. **[145D.40] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of sections 145D.40 to 145D.41, the following terms have the meanings given.

Subd. 2. **Assisted living facility.** "Assisted living facility" has the meaning given in section 144G.08, subdivision 7. Assisted living facility includes an assisted living facility with dementia care as defined in section 144G.08, subdivision 8.

Subd. 3. **Health care professional.** "Health care professional" means an individual who is licensed or registered by the state to provide health care services within the professional's scope of practice and in accordance with state law.

Subd. 4. **Nursing home.** "Nursing home" means a facility licensed as a nursing home under chapter 144A.

Subd. 5. **Ownership or control.** "Ownership or control" means the assumption of governance or the acquisition of an ownership interest or direct or indirect control by a for-profit entity over the operations of a nonprofit nursing home or a nonprofit assisted living facility through any means, including but not limited to a purchase, lease, transfer, exchange, option, conveyance, creation of a joint venture, or other manner of acquisition

of assets, governance, an ownership interest, or direct or indirect control of a nonprofit nursing home or a nonprofit assisted living facility.

Sec. 14. **[145D.41] NOTICE, INFORMATION, AND AFFIDAVIT REQUIRED.**

Subdivision 1. **Notice and information.** (a) At least 120 days prior to the transfer of ownership or control of a nonprofit nursing home or nonprofit assisted living facility to a for-profit entity, the nursing home or assisted living facility must provide written notice to the attorney general, the commissioner of health, and the commissioner of human services of its intent to transfer ownership or control to a for-profit entity.

(b) Together with the notice, the for-profit entity seeking to acquire ownership or control of the nonprofit nursing home or nonprofit assisted living facility must provide the following information to the attorney general, commissioner of health, and commissioner of human services:

(1) the names of each individual with an interest in the for-profit entity and the percentage of interest each individual holds in the for-profit entity;

(2) a complete and detailed description of the for-profit entity's corporate structure;

(3) the names of each individual holding an interest in, and the percentage of interest held in, any affiliate, subsidiary, or otherwise related entity that the for-profit entity has a contract to provide goods or services for the operation or maintenance of the nursing home or assisted living facility or has a contract for goods and services to be provided to residents, including any real estate investment trusts;

(4) for the previous five years, any filings required to be made to any federal or state agency;

(5) the for-profit entity's current balance sheet;

(6) all application materials required under section 144A.03 or 144G.12, as applicable;

(7) a description of the condition of the buildings the for-profit entity seeks to acquire or manage, identifying any cooling problems, electric medical devices present, recent exterior additions and replacements, external building conditions, recent flush toilet breakdowns, foreclosure status in the last 12 months, heat risk, heating problems, indoor air quality, recent interior additions and replacements, and mold, as those terms are defined and described in Appendix A of the American Housing Survey for the United States: 2023;

(8) an affidavit and evidence as required under subdivision 2; and

(9) other information required by the attorney general, commissioner of health, and commissioner of human services.

Subd. 2. **Affidavit and evidence.** In addition to the notice required under subdivision 1, a for-profit entity seeking to acquire ownership or control of a nonprofit nursing home or nonprofit assisted living facility must submit to the attorney general an affidavit and evidence sufficient to demonstrate that:

(1) the for-profit entity has the financial, managerial, and operational ability to operate or manage the nursing home or assisted living facility consistent with the requirements of (i) for a nursing home, sections 144A.01 to 144A.1888, chapter 256R, and Minnesota Rules, chapter 4658; or (ii) for an assisted living facility, chapter 144G and Minnesota Rules, chapter 4659;

(2) neither the for-profit entity nor any of its owners, managerial officials, or managers have committed a crime listed in, or been found civilly liable for an offense listed in section 144A.03, subdivision 1, clause (13), or 144G.12, subdivision 1, clause (13), as applicable;

(3) in the preceding ten years, there have been no judgments and no filed, pending, or completed public or private litigations, tax liens, written complaints, administrative actions, or investigations by a government agency against the for-profit entity or any of its owners, managerial officials, or managers;

(4) in the preceding ten years, the for-profit entity has not defaulted in the payment of money collected for others and has not discharged debts through bankruptcy proceedings;

(5) the for-profit entity will invest sufficient capital in the nursing home or assisted living facility to maintain or improve the facility's infrastructure and staffing;

(6)(i) housing costs or costs for services in a nursing home or assisted living facility in the United States over which the for-profit entity acquired ownership or control have not increased by more than the increase in the Consumer Price Index for all urban consumers published by the federal Bureau of Labor Statistics for the 12 months preceding the month in which the increase became effective; or (ii) if housing costs or costs for services in the nursing home or assisted living facility increased by more than the increase in the Consumer Price Index as described in item (i), the increase was justified;

(7) within five years after acquiring ownership or control of any other nursing home or assisted living facility in the United States, the for-profit entity did not sell or otherwise transfer ownership or control of the nursing home or assisted living facility to another person; and

(8) after acquiring ownership or control of another nursing home in the United States, that nursing home, with respect to the Centers for Medicare and Medicaid Services rating system:

(i) maintained or improved the nursing home's rating if upon acquisition of ownership or control the rating was three or more stars; or

(ii) improved the nursing home's rating to at least three stars if upon acquisition of ownership or control the rating was one or two stars.

Sec. 15. **[256.4751] MINNESOTA HOMELESS STUDY GRANTS.**

Subdivision 1. **Minnesota homeless study grant program established.** The commissioner shall establish a grant program for activities directly related to a triennial Minnesota homeless study.

Subd. 2. **Eligibility.** Minnesota-based nonprofits with experience conducting point-in-time studies of prevalence of homelessness in Minnesota are eligible for grants under this section.

Subd. 3. **Study administration and reporting.** Beginning in fiscal year 2027, the grantee must conduct a triennial point-in-time study that includes face-to-face interviews with people experiencing homelessness. The grantee must submit a copy of the Minnesota homeless study and a report that summarizes the findings of the study to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and housing and homelessness by March 1 of the year that is approximately 18 months after the date of the point-in-time study.

Subd. 4. **Minnesota homeless study account created.** A Minnesota homeless study account is created in the special revenue fund in the state treasury. Appropriations made for the Minnesota homeless study administered under this section must be transferred to this account. Money in the Minnesota homeless study account is appropriated to the commissioner of human services for purposes of this section. Notwithstanding section 16B.98, subdivision 14, for each fiscal year in which a grant is awarded under this section, the commissioner may use an amount not to exceed one percent of the money awarded.

Subd. 5. **Carryforward.** Notwithstanding section 16A.28, subdivision 3, money in the Minnesota homeless study account does not cancel.

Sec. 16. Minnesota Statutes 2024, 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; and

(9) assisting and cooperating with providers licensed under chapter 144G with the licensee's obligations under section 144G.55.

(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. If a county agency provides case management

under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) 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.

(e) 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.

(f) 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.

(g) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than 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 of human services. 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.

Sec. 17. Minnesota Statutes 2024, 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; and

(6) assisting and cooperating with providers licensed under chapter 144G with the licensee's obligations under section 144G.55.

(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. If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) 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.

(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 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 of human services. 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.

Sec. 18. **DIRECTION TO COMMISSIONER; COMPLIANCE COSTS AND REIMBURSEMENT RATES.**

(a) The commissioner of human services and the commissioner of health must convene a group of interested parties to examine the relationship between the costs incurred to comply with the licensing requirements under Minnesota Statutes, chapter 144G, and reimbursement rates for providing customized living services under Minnesota Statutes, chapter 256S, and section 256B.4914, subdivision 6d. The commissioners must include among the interested parties the Long-Term Care Imperative, the Residential Providers Association of Minnesota, the Minnesota Association of County Social Service Administrators, and people with disabilities currently receiving customized living services under the federally approved brain injury, community access for disability inclusion, and elderly waiver plans.

(b) The commissioners of human services and health must develop draft legislative language to better align the licensing requirements and reimbursement framework so that

the costs incurred to comply with licensing requirements and fees are adequately reimbursed through the rates paid for providing customized living services.

(c) The commissioners must submit the draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2027.

Sec. 19. **DIRECTION TO THE COMMISSIONER OF HEALTH; COMMUNITY CARE HUB GRANT.**

Subdivision 1. **Establishment.** The commissioner of health shall establish a single grant to expand and strengthen the community care hub model in Minnesota by organizing and supporting a network of health and social care service providers to address health-related social needs.

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

(b) "Community-based organization" means a public or private nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community and provides services that address the social drivers of health, education, or related services to individuals in the community.

(c) "Community care hub" means a nonprofit organization that provides a centralized administrative and operational interface between health care institutions and a network of community-based organizations that provide health promotion and social care services.

(d) "Health-related social needs" means the individual-level, adverse social conditions that can negatively impact a person's health or health care, such as poor health literacy, food insecurity, housing instability, and lack of access to transportation.

(e) "Social care services" means culturally informed services to address health-related social needs and community-informed health promotion programs.

Subd. 3. **Eligible applicants.** To be eligible for the single grant available under this section, a grant applicant must:

(1) be recognized as a selected community care hub by the federal Administration for Community Living and the Centers for Disease Control and Prevention;

(2) be the recipient of the community care hub planning grant under Laws 2024, chapter 127, article 53, section 3, subdivision 2, paragraph (a);

(3) hold contracts with health plans within Minnesota that allow the applicant to provide social care services to a plan's covered member population; and

(4) demonstrate active engagement in providing, coordinating, and aiding health care and social care services at the community level.

Subd. 4. **Eligible uses.** The grantee must use awarded money to:

(1) engage and organize community-based organizations to deliver social care services;

(2) expand the reach and scope of social care services;

(3) centralize administrative functions and operational infrastructure of community care hubs related to:

(i) contracting with health care organizations;

(ii) payment operations;

(iii) management of referrals, including reporting on the outcome of the services and the specific help provided;

(iv) service delivery fidelity and compliance;

(v) quality improvement;

(vi) technology;

(vii) information security; and

(viii) data collection, data analysis, and reporting;

(4) create sustainable financial pathways for services that address health-related social needs throughout the state of Minnesota; and

(5) support tracking of the financial pathways and the services provided.

Subd. 5. **Grantee report.** The grantee must report community care hub initiative outcomes as determined by the commissioner of health to the commissioner on the forms and according to the timelines established by the commissioner.

Subd. 6. **Evaluation.** The commissioner of health shall design, conduct, and evaluate the community care hub initiative implemented by the grantee using measures to assess cost savings, impact, and health impact outcomes.

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

Sec. 20. **RESIDENTIAL HOSPICE; IVY HOUSE.**

(a) Southern Minnesota Crisis Nursery, DBA Ivy House, may apply under Minnesota Statutes, sections 144A.75 to 144A.756, to be a licensed residential hospice facility as defined in Minnesota Statutes, section 144A.75, subdivision 13, paragraph (a). Nothing in this section shall be construed to require the commissioner of health to issue a license to an applicant that does not meet the licensing requirements under Minnesota Statutes, sections 144A.75 to 144A.756.

(b) If Southern Minnesota Crisis Nursery, DBA Ivy House, is issued a residential hospice facility license under Minnesota Statutes, sections 144A.75 to 144A.756, and meets all applicable enrollment criteria under Minnesota Statutes, chapter 256B, it may seek reimbursement for the provision of hospice respite and end-of-life care for children under Minnesota Statutes, section 256B.0625, subdivision 22a. Nothing in this section shall be construed to require the commissioner of human services to make payments to any provider of hospice respite or end-of-life care for children that the provider is not otherwise lawfully eligible to receive under Minnesota Statutes, chapter 256B.

ARTICLE 11
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 44. **Implementation of audit recommendations.** No later than February 1 each year following a year in which the Department of Human Services was subject to an audit under section 3.971, the commissioner must submit to the chairs and ranking minority members of the legislative committees with fiscal jurisdiction over the Department of Human Services a report detailing whether the department has implemented any recommendations identified during the prior five years by the legislative auditor in a financial audit, program evaluation, or special review. The report must include a specific itemization of recommendations that have not been implemented during that period, along with the basis for that decision.

Sec. 2. Laws 2023, chapter 61, article 1, section 61, subdivision 4, is amended to read:

Subd. 4. **Evaluation and report.** By December 1, 2024, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy an interim report on the impact and outcomes of the grants, including the number of grants awarded and the organizations receiving the

grants. The interim report must include any available evidence of how grantees were able to increase utilization of supported decision making and reduce or avoid more restrictive forms of decision making such as guardianship and conservatorship. By December 1, ~~2025~~ 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy a final report on the impact and outcomes of the grants, including any updated information from the interim report and the total number of people served by the grants. The final report must also detail how the money was used to achieve the requirements in subdivision 3, paragraph (b).

Sec. 3. Laws 2024, chapter 127, article 49, section 9, subdivision 1, is amended to read:

Subdivision 1. **Establishment; purpose.** The Mentally Ill and Dangerous Civil Commitment Reform Task Force is established to:

(1) evaluate current statutes related to mentally ill and dangerous civil commitments ~~and~~;

(2) evaluate current statutes related to the process by which a former patient may seek an order to expunge or vacate a prior commitment as mentally ill and dangerous; and

(3) develop recommendations to optimize the use of state-operated mental health resources and increase equitable access and outcomes for patients.

Sec. 4. Laws 2024, chapter 127, article 49, section 9, is amended by adding a subdivision to read:

Subd. 7a. **Duties; expungements and vacaturs.** The task force must:

(1) analyze current trends in civil commitments as mentally ill and dangerous, expungements, and vacaturs, including but not limited to the frequency of expungements and vacaturs in Minnesota as compared to other jurisdictions;

(2) review national practices and criteria for expunging and vacating civil commitments as mentally ill and dangerous;

(3) develop recommended statutory changes necessary to provide clear direction to former patients who are seeking to file a motion to expunge or vacate a civil commitment as mentally ill and dangerous;

(4) develop recommended statutory changes necessary to provide clear direction, criteria to apply, and evidentiary standards to the courts when considering a motion from a former patient to expunge or vacate a civil commitment as mentally ill and dangerous; and

(5) develop recommended statutory changes to provide clear direction to former patients and the courts to address situations in which an individual is civilly committed as mentally ill and dangerous and is later determined to not have an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory.

Sec. 5. Laws 2024, chapter 127, article 49, section 9, subdivision 8, is amended to read:

Subd. 8. **Report required.** (a) By August 1, 2025, the task force shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over mentally ill and dangerous civil commitments a written report that includes the outcome of the duties in subdivision 7, including but not limited to recommended statutory changes.

(b) By August 1, 2026, the task force shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over civil commitments a written report that includes the outcome of the duties in subdivision 7a, including but not limited to recommended statutory changes.

Sec. 6. Laws 2024, chapter 127, article 49, section 9, subdivision 9, is amended to read:

Subd. 9. **Expiration.** The task force expires January 1, ~~2026~~ 2027.

ARTICLE 12

DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of human services and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

		APPROPRIATIONS Available for the Year Ending June 30	
		2026	2027
Sec. 2. **TOTAL APPROPRIATION**	$	7,779,124,000	$ 7,976,910,000

Subdivision 1. **Appropriations by Fund**

	Appropriations by Fund	
	2026	2027
General	7,777,163,000	7,974,721,000
Lottery Prize	1,733,000	1,733,000
State Government Special Revenue Fund	228,000	456,000

The amounts that may be spent for each purpose are specified in the following sections and subdivisions.

Subd. 2. **Information Technology Appropriations**

(a) **IT Appropriations Generally**

This appropriation includes money for information technology projects, services, and support. Funding for information technology project costs must be incorporated into the service-level agreement and paid to Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for Systems Project**

Appropriations and federal receipts for information technology systems projects for MMIS and METS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services deems necessary. Any unexpended

balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Sec. 3. **CENTRAL OFFICE; OPERATIONS** **$ 4,309,000 $ 5,032,000**

Subdivision 1. **Budget and Legislative Staff**

$805,000 in fiscal year 2026 and $955,000 in fiscal year 2027 are for five additional full-time budget and legislative staff. The commissioner must not supplant existing spending on staff performing budget and legislative functions and must not supplement compensation of existing staff performing budget and legislative functions, but must use the money appropriated under this subdivision only to hire additional staff. This subdivision does not expire.

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $3,385,000 in fiscal year 2028 and $3,201,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE** **$ 1,066,000 $ 1,349,000**

Single Administrative Structure and Delivery System Pilot Program

$150,000 in fiscal year 2026 and $300,000 in fiscal year 2027 are for a contract to implement a web-based single administrative structure and delivery system for the delivery of nonemergency medical transportation. The base for this appropriation is $300,000 in fiscal year 2028, $300,000 in fiscal year 2029, and $0 in fiscal year 2030.

Sec. 5. **CENTRAL OFFICE; AGING AND DISABILITY SERVICES** **$ 13,707,000 $ 9,216,000**

Subdivision 1. **Provisional or Transitional Approval of Integrated Community Services Settings**

$150,000 in fiscal year 2026 is to develop draft legislative language to improve the process for approving integrated community support settings. This is a onetime appropriation.

Subd. 2. **Positive Supports Competency Program**

$1,000,000 in fiscal year 2026 is for the positive supports competency program. This is a onetime appropriation and is available until June 30, 2029.

Subd. 3. **Cost Reporting Improvement and Direct Care Staff Review**

$150,000 in fiscal year 2026 is to complete a cost reporting improvement study and direct care staffing review. This is a onetime appropriation.

Subd. 4. **Assisted Living Licensure and Disability Waiver Rate Study And Draft Legislation**

$100,000 in fiscal year 2026 is to complete a study on assisted living licensure and disability waiver reimbursement rates and to draft proposed legislation. This is a onetime appropriation.

Subd. 5. **Budget and Legislative Analysis**

$458,000 in fiscal year 2026 and $540,000 in fiscal year 2027 are for three additional full-time budget and legislative analysis staff. The commissioner must not supplant existing spending on staff performing budget and legislative analysis functions and must not supplement compensation of existing staff performing budget and legislative analysis

functions, but must use the money appropriated under this subdivision only to hire additional staff. This subdivision does not expire.

Subd. 6. **Base Level Adjustment**

The general fund base for this section is $7,201,000 in fiscal year 2028 and $5,755,000 in fiscal year 2029.

Sec. 6. **CENTRAL OFFICE; BEHAVIORAL HEALTH** **$ (39,000) $ 12,000**

Subdivision 1. **Fiscal Year 2026 Reduction**

The reduction in the fiscal year 2026 appropriation in this section is subtracted from appropriations to the Department of Human Services for behavioral health administration made in any other law enacted by the ninety-fourth legislature during the 2025 legislative session.

Subd. 2. **Substance Use Disorder Treatment Staff Report and Recommendations**

$100,000 in fiscal year 2026 and $50,000 in fiscal year 2027 are for a substance use disorder treatment staff report and recommendations. This is a onetime appropriation.

Subd. 3. **Base Level Adjustment**

The general fund base for this section is reduced by $38,000 in fiscal year 2028 and $38,000 in fiscal year 2029.

Sec. 7. **CENTRAL OFFICE; OFFICE OF INSPECTOR GENERAL** **$ 4,257,000 $ 5,105,000**

Subdivision 1. **Appropriations by Fund**

Appropriations by Fund		
	2026	2027

General	4,029,000	4,649,000
State Government Special Revenue	228,000	456,000

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $4,648,000 in fiscal year 2028 and $4,648,000 in fiscal year 2029.

Sec. 8. **FORECASTED PROGRAMS; HOUSING SUPPORT** **$ 323,000 $ 323,000**

Sec. 9. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE** **$ 7,445,352,000 $ 7,703,200,000**

Additional Critical Access Nursing Facility Funding

Up to $5,000,000 in fiscal year 2026 and up to $10,000,000 in fiscal year 2027 are for supplemental payments under Minnesota Statutes, section 256R.47, to designated critical access nursing facilities. The base for this appropriation is $17,500,000 in fiscal year 2028, $17,500,000 in fiscal year 2029, and $0 each year thereafter.

Sec. 10. **FORECASTED PROGRAMS; ALTERNATIVE CARE** **$ 55,694,000 $ 56,382,000**

Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Sec. 11. **FORECASTED PROGRAMS; BEHAVIORAL HEALTH FUND** **$ 138,575,000 $ 122,512,000**

Sec. 12. **GRANT PROGRAMS; CHILD AND COMMUNITY SERVICE GRANTS** **$ (5,655,000) $ (5,655,000)**

Fiscal Year 2026 and 2027 Reductions

The reductions in the fiscal year 2026 and fiscal year 2027 appropriations in this section are subtracted from appropriations to the

Department of Human Services for child and community service grants made in any other law enacted by the ninety-fourth legislature during the 2025 legislative session.

Sec. 13. **GRANT PROGRAMS; OTHER LONG-TERM CARE GRANTS** **$ 2,747,000 $ 1,925,000**

Home and Community-Based Services Incentive Pool

$2,747,000 in fiscal year 2026 and $1,925,000 in fiscal year 2027 are for the home and community-based services incentive pool under Minnesota Statutes, section 256B.0921.

Sec. 14. **GRANT PROGRAMS; AGING AND ADULT SERVICES GRANTS** **$ 40,804,000 $ 40,805,000**

Subdivision 1. **Age-Friendly Community Grants**

The base for this appropriation for age-friendly community grants under Minnesota Statutes, section 256.9747, subdivision 1, is $882,000 in fiscal year 2028 and $882,000 in fiscal year 2029.

Subd. 2. **Age-Friendly Technical Assistance Grants**

The base for this appropriation for age-friendly technical assistance grants under Minnesota Statutes, section 256.9747, subdivision 2, is $507,000 in fiscal year 2028 and $507,000 in fiscal year 2029.

Subd. 3. **Minnesota Board on Aging**

$788,000 in fiscal year 2026 and $788,000 in fiscal year 2027 are for the Minnesota Board on Aging under Minnesota Statutes, section 256.975, to add additional staff positions for the area agencies on aging contact centers to support senior LinkAge Line operations.

Subd. 4. **Senior Dining Programs**

$250,000 in fiscal year 2026 and $250,000 in fiscal year 2027 are for a competitive grant or grants to address the unique nutritional needs of older adults or to operate senior dining programs. The base for this appropriation is $400,000 in fiscal year 2028 and $400,000 in fiscal year 2029.

Subd. 5. **Long-Term Care Consultation Services Grants**

$1,739,000 in fiscal year 2026 and $1,739,000 in fiscal year 2027 are for grants for long-term care consultation services under Minnesota Statutes, section 256B.0911, and long-term care options counseling under Minnesota Statutes, section 256.975, subdivision 7.

Subd. 6. **Prescription Drug Assistance Program**

$1,191,000 in fiscal year 2026 and $1,191,000 in fiscal year 2027 are for a grant to the Board on Aging for the prescription drug assistance program under Minnesota Statutes, section 256.975, subdivision 9.

Subd. 7. **Core Home and Community-Based Service Projects**

$1,585,000 in fiscal year 2026 and $1,585,000 in fiscal year 2027 are for core home and community-based service projects under Minnesota Statutes, section 256.9754, subdivision 3d.

Subd. 8. **Caregiver Support and Respite Care Projects**

$479,000 in fiscal year 2026 and $479,000 in fiscal year 2027 are for caregiver support and

respite care projects under Minnesota Statutes, section 256.9754, subdivision 3c.

Subd. 9. **Community Services Development Grants**

$2,980,000 in fiscal year 2026 and $2,980,000 in fiscal year 2027 are for community services development grants under Minnesota Statutes, section 256.9754, subdivision 3.

Subd. 10. **Community Service Grants**

$3,128,000 in fiscal year 2026 and $3,128,000 in fiscal year 2027 are for community service grants under Minnesota Statutes, section 256.9754, subdivision 3e.

Subd. 11. **Customized Living Quality Improvement Grants**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are for customized living quality improvement grants under Minnesota Statutes, section 256.479.

Subd. 12. **Regional and Local Dementia Grants**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are for regional and local dementia grants under Minnesota Statutes, section 256.975, subdivision 11. The base for this appropriation is $1,500,000 in fiscal year 2028 and $1,500,000 in fiscal year 2029.

Subd. 13. **Eldercare Development Partnerships**

$1,758,000 in fiscal year 2026 and $1,758,000 in fiscal year 2027 are for eldercare development partnerships under Minnesota Statutes, section 256B.0917, subdivision 1c.

Subd. 14. **Gaps Analysis**

$218,000 in fiscal year 2026 and $218,000 in fiscal year 2027 are for analysis of gaps in long-term care services under Minnesota Statutes, section 144A.351.

Subd. 15. **Consumer Information and Assistance**

$3,449,000 in fiscal year 2026 and $3,449,000 in fiscal year 2027 are for a grant to the Board on Aging to provide information and assistance services under Minnesota Statutes, section 256.975, subdivision 7.

Subd. 16. **Minnesota Adult Abuse Reporting**

$1,819,000 in fiscal year 2026 and $1,819,000 in fiscal year 2027 are for a grant to the Minnesota Board on Aging to handle all reports of adult abuse for older adults and people with disabilities in various care settings.

Subd. 17. **Return to Community Services**

$9,341,000 in fiscal year 2026 and $9,341,000 in fiscal year 2027 are for a grant to the Board on Aging for return to community services under Minnesota Statutes, section 256.975, subdivision 7.

Subd. 18. **Preadmission Screening**

$817,000 in fiscal year 2026 and $817,000 in fiscal year 2027 are for a grant to the Board on Aging for preadmission screening under Minnesota Statutes, section 256.975, subdivisions 7a to 7d.

Subd. 19. **Direct Support Connect**

$236,000 in fiscal year 2026 and $236,000 in fiscal year 2027 are for a grant to the Board

on Aging for activities supporting Direct Support Connect.

Subd. 20. **Self-Directed Caregiver Grants**

$477,000 in fiscal year 2026 and $477,000 in fiscal year 2027 are for self-directed caregiver grants under Minnesota Statutes, section 256.975, subdivision 12.

Subd. 21. **Senior Nutrition Program**

$2,695,000 in fiscal year 2026 and $2,695,000 in fiscal year 2027 are for the senior nutrition program under Minnesota Statutes, section 256.9752. The base for senior nutrition programs under Minnesota Statutes, section 256.9752, is $2,820,000 in fiscal year 2028 and $2,820,000 in fiscal year 2029.

Subd. 22. **Senior Volunteer Programs**

$1,988,000 in fiscal year 2026 and $1,988,000 in fiscal year 2027 are for volunteer programs for retired senior citizens under Minnesota Statutes, section 256.9753; the foster grandparents program under Minnesota Statutes, section 256.976; and the senior companion program under Minnesota Statutes, section 256.977.

Subd. 23. **Adult Protection Grants**

$866,000 in fiscal year 2026 and $867,000 in fiscal year 2027 are for adult protection grants to counties and Tribes under Minnesota Statutes, section 256M.42.

Subd. 24. **Base Level Adjustment**

The general fund base for this section is $42,969,000 in fiscal year 2028 and $42,969,000 in fiscal year 2029.

Sec. 15. **DEAF, DEAFBLIND, AND HARD OF HEARING GRANTS** **$ 2,886,000 $ 2,886,000**

Sec. 16. **GRANT PROGRAMS; DISABILITY GRANTS** **$ 67,522,000 $ 28,293,000**

Subdivision 1. **Self-Directed Bargaining Agreement; Orientation Start-Up Funds**

$3,000,000 in fiscal year 2026 is for orientation program start-up costs as defined by the SEIU collective bargaining agreement. This is a onetime appropriation.

Subd. 2. **Self-Directed Bargaining Agreement; Orientation Ongoing Funds**

$2,000,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are for ongoing costs related to the orientation program as defined by the SEIU collective bargaining agreement.

Subd. 3. **Self-Directed Bargaining Agreement; Training Stipends**

$2,250,000 in fiscal year 2026 is for onetime stipends of $750 for collective bargaining unit members for training. This is a onetime appropriation.

Subd. 4. **Self-Directed Bargaining Agreement; Retirement Trust Funds**

$350,000 in fiscal year 2026 is for a vendor to create a retirement trust, as defined by the SEIU collective bargaining agreement. This is a onetime appropriation.

Subd. 5. **Self-Directed Bargaining Agreement; Health Care Stipends**

$30,750,000 in fiscal year 2026 is for stipends of $1,200 for each collective bargaining unit member for retention and defraying any health insurance costs the member may incur. Stipends are available once per fiscal year per

member for fiscal year 2026 and fiscal year 2027. Of this amount, $30,000,000 in fiscal year 2026 is for stipends and $750,000 in fiscal year 2026 is for administration. This is a onetime appropriation and is available until June 30, 2027.

Subd. 6. **Disability Services Technology And Advocacy Expansion Grant**

(a) $226,000 in fiscal year 2026 and $220,000 in fiscal year 2027 are for the disability services technology and advocacy expansion grant under Minnesota Statutes, section 256.4768. The general fund base for this purpose is $220,000 in fiscal year 2028, $220,000 in fiscal year 2029, $220,000 in fiscal year 2030, and $0 in fiscal year 2031.

(b) This subdivision expires June 30, 2030.

Subd. 7. **Disability Inclusion Pilot Project**

(a) $816,000 in fiscal year 2026 is for a competitive grant for a statewide disability inclusion pilot project. This is a onetime appropriation.

(b) The pilot project must:

(1) persuade employers to diversify their workforces by hiring people with disabilities;

(2) educate businesses on the economic benefits of inclusive employment and provide coaching on affordable accommodations;

(3) educate Minnesotans with disabilities and their families on navigating services and achieving inclusion in both work and community settings;

(4) build capacity and support for culturally specific services by rural, Black, Indigenous, or People of Color entrepreneurs;

(5) pilot community-requested support services;

(6) invest in safe community-focused spaces to host trainings and requested support services; and

(7) launch a statewide disability inclusion assessment for businesses and community spaces to improve accessibility and inclusion.

(c) The pilot project must reach all six Minnesota planning areas to ensure equal access to the pilot project activities in rural and Tribal regions.

Subd. 8. **Direct Support Professional Development**

(a) $230,000 in fiscal year 2026 is for a competitive grant to:

(1) develop curriculum for a pretraining program tailored to the educational needs of potential direct support professionals;

(2) provide workforce readiness training for individuals entering the field of direct care and support services;

(3) expand recruitment efforts to increase direct support professional workforce capacity, particularly among diverse and underrepresented communities; and

(4) collaborate with community-based organizations, educational institutions, and providers to support the long-term

development of the direct support professionals workforce.

(b) This is a onetime appropriation.

Subd. 9. **Technology for Home Grants**

$922,000 in fiscal year 2026 and $922,000 in fiscal year 2027 are for technology for home grants under Minnesota Statutes, section 256.4773.

Subd. 10. **Self-Advocacy Grants for Persons with Intellectual and Developmental Disabilities**

$248,000 in fiscal year 2026 and $248,000 in fiscal year 2027 are for self-advocacy grants under Minnesota Statutes, section 256.477. Of these amounts:

(1) $143,000 in fiscal year 2026 and $143,000 in fiscal year 2027 are for the activities under Minnesota Statutes, section 256.477, subdivision 1, paragraph (a), and for administrative costs associated with those activities incurred by the grantee; and

(2) $105,000 in fiscal year 2026 and $105,000 in fiscal year 2027 are for the activities under Minnesota Statutes, section 256.477, subdivision 2.

Subd. 11. **Case Management Training Grants**

$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.

Subd. 12. **Family Support Program**

$9,423,000 in fiscal year 2026 and $9,096,000 in fiscal year 2027 are for support grants under Minnesota Statutes, section 252.32.

Subd. 13. **Disability Hub for Families Grants**

$200,000 in fiscal year 2026 and $200,000 in fiscal year 2027 are for grants under Laws 2019, First Special Session chapter 9, article 14, section 2, subdivision 29, paragraph (e), to connect families through innovation grants, life planning tools, and website information as they support a child or family member with disabilities.

Subd. 14. **Disability Hub**

$1,716,000 in fiscal year 2026 and $2,041,000 in fiscal year 2027 are for the Disability Hub under Minnesota Statutes, section 256.01, subdivision 24.

Subd. 15. **Minnesota Aging and Disability Resource Center**

$900,000 in fiscal year 2026 and $900,000 in fiscal year 2027 are for grants under Minnesota Statutes, section 256.01, subdivision 2, paragraph (z), to support the Minnesota Aging and Disability Resource Center.

Subd. 16. **Day Training and Habilitation Facility Grants**

$811,000 in fiscal year 2026 and $811,000 in fiscal year 2027 are for grant allocations to counties for day training and habilitation services for adults with developmental disabilities when provided as a social service

under Minnesota Statutes, sections 252.41 to 252.46.

Subd. 17. **Employment and Technical Assistance Center Grants**

$450,000 in fiscal year 2026 and $1,800,000 in fiscal year 2027 are for employment and technical assistance grants to assist organizations and employers in promoting a more inclusive workplace for people with disabilities.

Subd. 18. **Grant to Family Voices in Minnesota**

$75,000 in fiscal year 2026 and $75,000 in fiscal year 2027 are for a grant to Family Voices in Minnesota under Minnesota Statutes, section 256.4776.

Subd. 19. **Intractable Epilepsy Demonstration Project**

$344,000 in fiscal year 2026 and $344,000 in fiscal year 2027 are for the demonstration project established under Laws 1988, chapter 689, article 2, section 251, and a grant to a nonresidential program that provides medical monitoring and living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living. The grant awarded under this section must be used for salaries, administration, transportation, and other program costs.

Subd. 20. **Lead Agency Capacity-Building Grants**

$2,413,000 in fiscal year 2026 and $2,411,000 in fiscal year 2027 are for grants to assist organizations, counties, and Tribes to build capacity for employment opportunities for people with disabilities.

Subd. 21. **Minnesota Inclusion Initiative Grants**

$150,000 in fiscal year 2026 and $150,000 in fiscal year 2027 are from the general fund for grants under Minnesota Statutes, section 256.4772.

Subd. 22. **MnCHOICES Modifications**

$450,000 in fiscal year 2026 and $125,000 in fiscal year 2027 are for enhancements to the MnCHOICES assessment tool to provide real-time employment information, communication, and resources, supporting individuals and professionals in improving education, engagement, and access to employment opportunities.

Subd. 23. **Parent-to-Parent USA Peer Support**

$125,000 in fiscal year 2026 and $125,000 in fiscal year 2027 are for a grant to an alliance member of Parent-to-Parent USA under Minnesota Statutes, section 256.4776.

Subd. 24. **Preadmission Screening and Resident Reviews for Persons with Mental Illness or Developmental Disabilities**

$20,000 in fiscal year 2026 and $20,000 in fiscal year 2027 are for reimbursement to counties for costs associated with completing federally required preadmission screening and resident reviews of nursing home applicants or residents with a probable mental illness or a developmental disability.

Subd. 25. **Regional Support for Person-Centered Practices Grants**

$710,000 in fiscal year 2026 and $710,000 in fiscal year 2027 are for grants to regional cohorts to extend and expand regional capacity

for person-centered planning through training, coaching, and mentoring for person-centered and collaborative safety practices benefiting people with disabilities and employees, organizations, and communities serving people with disabilities.

Subd. 26. **Region 10 Grants**

$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are for a grant provided under Minnesota Statutes, section 256B.097.

Subd. 27. **Semi-Independent Living Services Grants**

$7,229,000 in fiscal year 2026 and $7,229,000 in fiscal year 2027 are for semi-independent living services grants under Minnesota Statutes, section 252.275.

Subd. 28. **Case Management Supportive Services for People Living with HIV/AIDS**

$1,156,000 in fiscal year 2026 and $1,156,000 in fiscal year 2027 are for grants to community-based HIV/AIDS supportive services providers as defined in Minnesota Statutes, section 256.01, subdivision 19.

Subd. 29. **Health Care Coverage for People Living with HIV/AIDS**

$1,064,000 in fiscal year 2026 and $1,064,000 in fiscal year 2027 are for payment of allowed health care costs under Minnesota Statutes, section 256.9365.

Subd. 30. **State Quality Council**

$600,000 in fiscal year 2026 and $600,000 in fiscal year 2027 are for the State Quality Council under Minnesota Statutes, section 256B.097, to provide technical assistance and

monitoring of person-centered outcomes related to inclusive community living and employment. The funding must be used by the State Quality Council to execute a statewide plan for a systems change in person-centered planning that will achieve desired outcomes, including increased integrated employment and community living.

Subd. 31. **Transition to Community Initiative**

$1,811,000 in fiscal year 2026 and $1,811,000 in fiscal year 2027 are for the transition to community initiative under Minnesota Statutes, section 256.478.

Subd. 32. **Self-Directed Bargaining Agreement; Training Stipends; Allocation Correction**

$87,000 in fiscal year 2026 and $87,000 in fiscal year 2027 are to correct a funding allocation mistake for stipends for collective bargaining unit members initially appropriated under Laws 2017, First Special Session chapter 6, article 18, section 2, subdivision 15, paragraph (b), clause (2).

Subd. 33. **Base Level Adjustments**

The general fund base for this section is $28,293,000 in fiscal year 2028 and $28,293,000 in fiscal year 2029.

Sec. 17. **GRANT PROGRAMS; HOUSING SUPPORT GRANTS** **$ 450,000 $ 450,000**

Minnesota Homeless Study

$450,000 in fiscal year 2026 and $450,000 in fiscal year 2027 are for the Minnesota homeless study under Minnesota Statutes, section 256.4751.

Sec. 18. **GRANT PROGRAMS; ADULT MENTAL HEALTH GRANTS** **$ 1,300,000 $ 250,000**

Subdivision 1. **Health Services and Support Grants**

$1,300,000 in fiscal year 2026 and $250,000 in fiscal year 2027 are for competitive grants to provide health services and supports to communities that are underserved due to language or demographic barriers. The amounts appropriated in fiscal years 2026 and 2027 are available until June 30, 2029. The base for this appropriation is $500,000 in fiscal year 2028 and $500,000 in fiscal year 2029.

Subd. 2. **Base Level Adjustments**

The general fund base for this section is $500,000 in fiscal year 2028 and $500,000 in fiscal year 2029.

Sec. 19. **GRANT PROGRAMS; CHEMICAL DEPENDENCY TREATMENT SUPPORT GRANTS** **$ 5,826,000 $ 4,825,000**

Subdivision 1. **Appropriations by Fund**

Appropriations by Fund		
	2026	2027
General	4,093,000	3,092,000
Lottery Prize	1,733,000	1,733,000

Subd. 2. **Problem Gambling**

$225,000 in fiscal year 2026 and $225,000 in fiscal year 2027 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.

Subd. 3. **Recovery Community Grants**

$1,475,000 in fiscal year 2026 and $775,000 in fiscal year 2027 are from the general fund for competitive grants to recovery community organizations serving underserved communities or geographic locations.

Subd. 4. **Suicide Prevention Grants**

$435,000 in fiscal year 2026 and $434,000 in fiscal year 2027 are from the general fund for a competitive grant for activities designed to enhance culturally relevant services and resources for Minnesota's African immigrant refugee community related to mental health, substance use disorder, and suicide prevention. Grant money may also be used to address the physical and mental wellness needs of the elderly and mental health support and suicide prevention for underrepresented students in higher education. This is a onetime appropriation and is available until June 30, 2027.

Subd. 5. **Peer Specialists**

$300,000 in fiscal year 2026 is for peer specialists grants first established under Laws 2016, chapter 189, article 23, section 2, subdivision 4, paragraph (f). This is a onetime appropriation.

Subd. 6. **American Indian Programs**

$1,397,000 in fiscal year 2026 and $1,397,000 in fiscal year 2027 are from the general fund for the American Indian programs under

Minnesota Statutes, section 254A.03, subdivision 2.

Subd. 7. **Methamphetamine Treatment Grant**

$125,000 in fiscal year 2026 and $125,000 in fiscal year 2027 are from the general fund for a grant to a nonprofit organization to treat methamphetamine abuse and the abuse of other substances. The focus audience is women with dependent children identified as substance abusers, especially those whose most-used controlled substance is methamphetamine.

Subd. 8. **Base Level Adjustment**

The general fund base for this section is $2,658,000 in fiscal year 2028 and $2,658,000 in fiscal year 2029.

Sec. 20. Laws 2023, chapter 61, article 9, section 2, subdivision 13, is amended to read:

Subd. 13. **Grant Programs; Other Long-Term Care Grants**	152,387,000	1,925,000

(a) **Provider Capacity Grant for Rural and Underserved Communities.** $17,148,000 in fiscal year 2024 is for provider capacity grants for rural and underserved communities. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(b) **New American Legal, Social Services, and Long-Term Care Grant Program.** $28,316,000 in fiscal year 2024 is for long-term care workforce grants for new Americans. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is

available until June 30, 2027. This is a onetime appropriation.

(c) **Supported Decision Making Programs.** $4,000,000 in fiscal year 2024 is for supported decision making grants. This is a onetime appropriation and is available until June 30, ~~2025~~ 2026.

(d) **Direct Support Professionals Employee-Owned Cooperative Program.** $350,000 in fiscal year 2024 is for a grant to the Metropolitan Consortium of Community Developers for the Direct Support Professionals Employee-Owned Cooperative program. The grantee must use the grant amount for outreach and engagement, managing a screening and selection process, providing one-on-one technical assistance, developing and providing training curricula related to cooperative development and home and community-based waiver services, administration, reporting, and program evaluation. This is a onetime appropriation and is available until June 30, 2025.

(e) **Long-Term Services and Supports Workforce Incentive Grants.** $83,560,000 in fiscal year 2024 is for long-term services and supports workforce incentive grants administered according to Minnesota Statutes, section 256.4764. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2029. This is a onetime appropriation.

(f) **Base Level Adjustment.** The general fund base is $3,949,000 in fiscal year 2026 and $3,949,000 in fiscal year 2027. Of these

amounts, $2,024,000 in fiscal year 2026 and $2,024,000 in fiscal year 2027 are for PCA background study grants.

Sec. 21. Laws 2023, chapter 61, article 9, section 2, subdivision 16, as amended by Laws 2023, chapter 70, article 15, section 8, and Laws 2024, chapter 125, article 8, section 14, is amended to read:

Subd. 16. **Grant Programs; Disabilities Grants**	113,684,000	30,377,000

(a) **Temporary Grants for Small Customized Living Providers.** $5,450,000 in fiscal year 2024 is for grants to assist small customized living providers to transition to community residential services licensure or integrated community supports licensure. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(b) **Lead Agency Capacity Building Grants.** $444,000 in fiscal year 2024 and $2,396,000 in fiscal year 2025 are for grants to assist organizations, counties, and Tribes to build capacity for employment opportunities for people with disabilities. The base for this appropriation is $2,413,000 in fiscal year 2026 and $2,411,000 in fiscal year 2027.

(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 and $123,000 in fiscal year 2025 are for grants to provide case

management training to organizations and employers to support the state's disability employment supports system. The base for this appropriation is $45,000 in fiscal year 2026 and $45,000 in fiscal year 2027.

(e) **Self-Directed Bargaining Agreement; 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. Of this amount, $5,600,000 is for stipends and $495,000 is for administration. 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. Of this amount, $1,400,000 of the appropriation is for stipends and $200,000 is for administration. 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. Of this amount, $50,000,000 is for retention bonuses and

$750,000 is for administration of the bonuses. This is a onetime appropriation and is available until June 30, 2025.

(h) **Self-Directed Bargaining Agreement; 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. Of this amount, $2,000,000 in fiscal year 2024 is for stipends, and $100,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are for administration. This is a onetime appropriation.

(i) **Self-Directed Bargaining Agreement; Orientation Program.** $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are for onetime $100 payments to collective bargaining unit members who complete voluntary orientation requirements. Of this amount, $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for the onetime $100 payments, and $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for orientation-related costs. This is a onetime appropriation.

(j) **Self-Directed Bargaining Agreement; Home Care Orientation Trust.** $1,000,000 in fiscal year 2024 is for the Home Care Orientation Trust under Minnesota Statutes, section 179A.54, subdivision 11. The commissioner shall disburse the appropriation to the board of trustees of the Home Care Orientation Trust for deposit into an account

designated by the board of trustees outside the state treasury and state's accounting system. This is a onetime appropriation and is available until June 30, 2025.

(k) **HIV/AIDS Supportive Services.** $12,100,000 in fiscal year 2024 is for grants to community-based HIV/AIDS supportive services providers as defined in Minnesota Statutes, section 256.01, subdivision 19, and for payment of allowed health care costs as defined in Minnesota Statutes, section 256.9365. This is a onetime appropriation and is available until June 30, 2025.

(l) **Motion Analysis Advancements Clinical Study and Patient Care.** $400,000 ~~is~~ in fiscal year 2024 is for a grant to the Mayo Clinic Motion Analysis Laboratory and Limb Lab for continued research in motion analysis advancements and patient care. This is a onetime appropriation and is available through June 30, ~~2025~~ 2027.

(m) **Grant to Family Voices in Minnesota.** $75,000 in fiscal year 2024 and $75,000 in fiscal year 2025 are for a grant to Family Voices in Minnesota under Minnesota Statutes, section 256.4776.

(n) **Parent-to-Parent Programs.**

(1) $550,000 in fiscal year 2024 and $550,000 in fiscal year 2025 are for grants to organizations that provide services to underserved communities with a high prevalence of autism spectrum disorder. This is a onetime appropriation and is available until June 30, 2025.

(2) 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 paragraph, "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.

(o) **Self-Advocacy Grants for Persons with Intellectual and Developmental Disabilities.** $323,000 in fiscal year 2024 and $323,000 in fiscal year 2025 are for self-advocacy grants under Minnesota Statutes, section 256.477. This is a onetime appropriation. Of these amounts, $218,000 in fiscal year 2024 and $218,000 in fiscal year 2025 are for the activities under Minnesota Statutes, section 256.477, subdivision 1, paragraph (a), clauses (5) to (7), and for administrative costs, and $105,000 in fiscal year 2024 and $105,000 in fiscal year 2025 are for the activities under Minnesota Statutes, section 256.477, subdivision 2.

(p) **Technology for Home Grants.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for technology for home grants under Minnesota Statutes, section 256.4773.

(q) **Community Residential Setting Transition.** $500,000 in fiscal year 2024 is for a grant to Hennepin County to expedite approval of community residential setting licenses subject to the corporate foster care moratorium exception under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (a), clause (5).

(r) **Base Level Adjustment.** The general fund base is $27,343,000 in fiscal year 2026 and $27,016,000 in fiscal year 2027.

Sec. 22. Laws 2024, chapter 127, article 53, section 2, subdivision 13, is amended to read:

Subd. 13. **Grant Programs; Aging and Adult Services Grants**	-0-	4,500,000

(a) **Caregiver Respite Services Grants.** $2,000,000 in fiscal year 2025 is for caregiver respite services grants under Minnesota Statutes, section 256.9756. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(b) **Caregiver Support Programs.** $2,500,000 in fiscal year 2025 is for the Minnesota Board on Aging for the purposes of the caregiver support programs under Minnesota Statutes, section 256.9755. Programs receiving funding under this paragraph must include an ALS-specific respite service in their caregiver support program. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, ~~2027~~ 2028.

Sec. 23. Laws 2024, chapter 127, article 53, section 2, subdivision 15, is amended to read:

Subd. 15. **Grant Programs; Adult Mental Health Grants**	(8,900,000)	2,364,000

(a) **Locked Intensive Residential Treatment Services.** $1,000,000 in fiscal year 2025 is for start-up funds to intensive residential treatment services providers to provide treatment in locked facilities for patients meeting medical necessity criteria and who may also be referred for competency attainment or a competency examination under Minnesota Statutes, sections 611.40 to 611.59. This is a onetime

appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(b) **Engagement Services Pilot Grants.** $1,500,000 in fiscal year 2025 is for engagement services pilot grants. Of this amount, $250,000 in fiscal year 2025 is for an engagement services pilot grant to Otter Tail County. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, ~~2026~~ 2028.

(c) **Mental Health Innovation Grant Program.** $1,321,000 in fiscal year 2025 is for the mental health innovation grant program under Minnesota Statutes, section 245.4662. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2026.

(d) **Behavioral Health Services For Immigrant And Refugee Communities.** $354,000 in fiscal year 2025 is for a payment to African Immigrant Community Services to provide culturally and linguistically appropriate services to new Americans with disabilities, mental health needs, and substance use disorders and to connect such individuals with appropriate alternative service providers to ensure continuity of care. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(e) **Base Level Adjustment.** The general fund base is decreased by $1,811,000 in fiscal year

2026 and decreased by $1,811,000 in fiscal year 2027.

Sec. 24. **TRANSFERS AND GRANT CANCELLATIONS AND ELIMINATIONS.**

Subdivision 1. **Local planning grant elimination.** The fiscal year 2026 and fiscal year 2027 general fund base appropriations for local planning grants for creating alternatives to congregate living for individuals with lower needs first established under Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 4, paragraph (k), are reduced from $254,000 to $0.

Subd. 2. **Chemical dependency peer specialists grant elimination.** The fiscal year 2027 general fund base appropriation for grants for peer specialists first established under Laws 2016, chapter 189, article 23, section 2, subdivision 4, paragraph (f), is reduced from $725,000 to $0.

Subd. 3. **Community residential setting transitional grant cancellation.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 16, paragraph (a), for grants to assist small customized living providers to transition to community residential services licensure or integrated community supports licensure, estimated to be $5,450,000, is canceled.

Subd. 4. **Retention bonus cancellation.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 16, paragraph (g), for retention bonuses, estimated to be $27,000,000, is canceled.

Subd. 5. **Orientation payments cancellation.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation referenced in Laws 2023, chapter 61, article 9, section 2, subdivision 16, paragraph (i), for orientation payments, estimated to be $1,830,000, is canceled.

Subd. 6. **Safe recovery site grant cancellation.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 18, paragraph (b), for grants to establish safe recovery sites, estimated to be $13,528,000, is canceled.

Subd. 7. **Harm reduction grant cancellation.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 18, paragraph (e), for grants to purchase syringes, testing supplies, and opiate antagonists, estimated to be $7,597,000, is canceled.

Subd. 8. **Nursing facility payment program cancellation.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 74, article 1, section 6, subdivision 2, for payments to nursing facilities, estimated to be $1,416,000, is canceled.

Subd. 9. **Advisory committee for Direct Care and Treatment funding cancellation.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 127, article 53, section 2, subdivision 20, paragraph (d), for the Direct Care and Treatment advisory committee, estimated to be $482,000, is canceled.

Subd. 10. **Cancellation and transfer of the human services response contingency account balance.** (a) $813,000 of the remaining unencumbered balance in the human services response contingency account established under Minnesota Statutes, section 256.044, is canceled to the special revenue fund.

(b) An amount equal to the amount canceled under paragraph (a) is transferred from the special revenue fund to the general fund.

Subd. 11. **Cancellation and transfer of family and medical benefit funding.** (a) $20,000,000 in fiscal year 2026 is canceled from the family and medical benefit account to the family and medical benefit insurance fund.

(b) An amount equal to the amount canceled under paragraph (a) is transferred from the family and medical benefit insurance fund to the general fund.

Subd. 12. **Transfer from the opiate epidemic response fund to the general fund.** The commissioner of management and budget must transfer $1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 from the registration and license fee account in the opiate epidemic response fund under Minnesota Statutes, section 256.043, subdivision 3, to the general fund. For fiscal years 2028 to 2031, the commissioner of management and budget must include a transfer of $1,000,000 each year from the registration and license fee account in the opiate epidemic response fund to the general fund when preparing each forecast under Minnesota Statutes, section 16A.103, from the effective date of this subdivision through the February 2027 forecast.

Subd. 13. **Transfers to and from the workforce incentive grant account.** (a) By July 30, 2025, the commissioner must transfer $70,805,000 from the workforce incentive grant account in the special revenue fund, under Minnesota Statutes, section 256.4764, subdivision 9, to the general fund. This is a onetime transfer.

(b) In fiscal year 2028, the commissioner must transfer $70,805,000 from the general fund to the workforce incentive grant account in the special revenue fund under Minnesota Statutes, section 256.4764, subdivision 9. This is a onetime transfer and is available for the purposes of the account until June 30, 2029. Any remaining balance cancels to the general fund.

Subd. 14. **Transfer from the long-term services and supports loan account to the general fund.** The commissioner of management and budget must transfer unencumbered money from the long-term services and supports loan account under Minnesota Statutes, section 256.4792, subdivision 8a, in the special revenue fund, to the general fund. The amounts transferred must not exceed $5,000,000 in fiscal year 2026 and $10,000,000 in fiscal year 2027. For fiscal years 2028 through 2031, the commissioner of management and budget must include an assumption that a transfer of $17,500,000 in fiscal year 2028, $17,500,000 in fiscal year 2029, and $0 each year thereafter of unencumbered money in the long-term services and supports loan account from the special revenue fund to the general fund, when preparing each forecast from the effective date of this section through the February 2027 forecast, under Minnesota Statutes, section 16A.103.

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

Sec. 25. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the advance approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2027, within fiscal years among general assistance, medical assistance, MinnesotaCare, the Minnesota supplemental aid program, the housing support program, and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a quarterly grants transfer report. The report must include the amounts transferred and the purpose of each transfer.

Subd. 2. **Administration; intra-agency transfers.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioner deems necessary, with the advance approval of the commissioner of management and budget. The commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance a quarterly intra-agency transfer report. The report must include the amounts transferred and the purpose of each transfer.

Subd. 3. **Administration; interagency transfers.** During fiscal year 2026, with advance approval of the commissioner of management and budget, administrative money may be transferred between the Department of Human Services and Direct Care and Treatment as the commissioner and executive board deem necessary. The commissioner and executive board must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and direct care and treatment an interagency transfers report. The report must include the amounts transferred and the purpose of each transfer.

Sec. 26. **GRANT ADMINISTRATION.**

Notwithstanding Minnesota Statutes, section 16B.98, subdivision 14, the commissioner of human services must not use any of the grant amounts appropriated under this article for administrative costs.

Sec. 27. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation or transfer in this article is enacted more than once during the 2025 regular session, the appropriation or transfer must be given effect once.

Sec. 28. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit.

Sec. 29. **EFFECTIVE DATE.**

This article is effective July 1, 2025, unless a different effective date is specified.

ARTICLE 13

DIRECT CARE AND TREATMENT APPROPRIATIONS

Section 1. **DIRECT CARE AND TREATMENT APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the executive board of direct care and treatment and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

APPROPRIATIONS
Available for the Year

		Ending June 30	
		2026	2027
Sec. 2. **EXECUTIVE BOARD OF DIRECT CARE AND TREATMENT; TOTAL APPROPRIATION**	$	577,915,000	$ 603,261,000

The amounts that may be spent for each purpose are specified in the following sections.

Sec. 3. **MENTAL HEALTH AND SUBSTANCE ABUSE**	$	189,761,000	$ 194,840,000
Sec. 4. **COMMUNITY-BASED SERVICES**	$	13,927,000	$ 14,170,000
Sec. 5. **FORENSIC SERVICES**	$	160,239,000	$ 164,094,000
Sec. 6. **SEX OFFENDER PROGRAM**	$	128,050,000	$ 131,351,000
Sec. 7. **ADMINISTRATION**	$	85,938,000	$ 98,806,000

Subdivision 1. **Locked Psychiatric Residential Treatment Facility Planning**

(a) $100,000 in fiscal year 2026 is for planning a build out of a locked psychiatric residential treatment facility operated by Direct Care and Treatment. This is a onetime appropriation and is available until June 30, 2027.

(b) By March 1, 2026, the executive board must report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy on the plan developed using the appropriation in this section to build out a locked psychiatric residential treatment facility (PRTF) operated by Direct Care and Treatment.

(c) The report must include but is not limited to the following information:

(1) the risks and benefits of locating the locked PRTF in a metropolitan or rural location;

(2) the estimated cost for the build out of the locked PRTF;

(3) the estimated ongoing cost of maintaining the locked PRTF; and

(4) the estimated amount of costs that can be recouped from medical assistance, MinnesotaCare, and private insurance payments.

Subd. 2. **Mentally Ill and Dangerous Commitment Reform Task Force Extension, Report, and Recommendations**

$31,000 in fiscal year 2026 and $31,000 in fiscal year 2027 are for the administrative costs associated with the extension of the Mentally Ill and Dangerous Commitment Reform Task Force and preparing the recommendations and report of the task force. This is a onetime appropriation.

Subd. 3. **Base Level Adjustment**

The general fund base for this section is $173,775,000 in fiscal year 2028 and $98,775,000 in fiscal year 2029. The base for fiscal year 2028 includes $75,000,000 for the renovation of the Anoka Regional Treatment Center Miller Building.

Sec. 8. **TRANSFER AUTHORITY.**

Subdivision 1. **Interprogrammatic transfers.** Money appropriated for budget programs in this article may be transferred between budget programs and between years of the biennium with the approval of the commissioner of management and budget.

Subd. 2. **Security systems and information technology transfer.** The Direct Care and Treatment executive board, with the advance approval of the commissioner of management and budget, may transfer money appropriated for Direct Care and Treatment into the special revenue account for security systems and information technology projects, services, and

support. The executive board must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over Direct Care and Treatment a quarterly security systems and information technology transfer report. The report must include the amounts transferred in that period and the purpose of each transfer.

Subd. 3. **Facilities management transfer.** The Direct Care and Treatment executive board, with the advance approval of the commissioner of management and budget, may transfer money appropriated for Direct Care and Treatment into the special revenue account for facilities management. The executive board must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over Direct Care and Treatment a quarterly facilities management transfer report. The report must include the amounts transferred in that period and the purpose of each transfer.

Subd. 4. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within Direct Care and Treatment as the executive board considers necessary, with the advance approval of the commissioner of management and budget. The executive board must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over Direct Care and Treatment a quarterly intra-agency transfer report. The report must include the amounts transferred in that period and the purpose of each transfer.

Subd. 5. **Administration; interagency transfers.** During fiscal year 2026, administrative money may be transferred between the Department of Human Services and Direct Care and Treatment as the commissioner and executive board deem necessary, with advance approval of the commissioner of management and budget. The commissioner and executive board shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and direct care and treatment an interagency transfers report. The report must include the amounts transferred and the purpose of each transfer.

Sec. 9. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation or transfer in this article is enacted more than once during the 2025 regular session, the appropriation or transfer must be given effect once.

Sec. 10. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit.

Sec. 11. **EFFECTIVE DATE.**

This article is effective July 1, 2025, unless a different effective date is specified.

ARTICLE 14

HEALTH APPROPRIATIONS

Section 1. **HEALTH APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF HEALTH; TOTAL APPROPRIATION**	**$ 3,092,000**	**$ 2,996,000**
The amounts that may be spent for each purpose are specified in the following sections.		
Sec. 3. **HEALTH IMPROVEMENT**	**$ 2,836,000**	**$ 2,836,000**
Subdivision 1. **Community Care Hub Grant**		
$2,240,000 in fiscal year 2026 and $2,240,000 in fiscal year 2027 are for the community care hub grant.		
Subd. 2. **Spinal Cord and Traumatic Brain Injury Research**		
$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are for a transfer to the spinal cord and traumatic brain injury grant account in the special revenue fund under Minnesota Statutes, section 136A.901, subdivision 1. The commissioner of management and budget must include a transfer of $500,000 each year from		

the general fund to the spinal cord and traumatic brain injury grant account in each forecast prepared under Minnesota Statutes, section 16A.103.

Sec. 4. **HEALTH PROTECTION** **$ 256,000 $ 160,000**

Subdivision 1. **Skin-Lightening Product Awareness**

$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are for a competitive grant for public awareness and education activities to address issues of colorism, skin-lightening products, and chemical exposures from skin-lightening products. This is a onetime appropriation and is available until June 30, 2027.

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $60,000 in fiscal year 2028 and $60,000 in fiscal year 2029.

Sec. 5. **GRANT ADMINISTRATION.**

Notwithstanding Minnesota Statutes, section 16B.98, subdivision 14, the commissioner of health must not use any of the grant amounts appropriated under this article for administrative costs.

Sec. 6. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation or transfer in this article is enacted more than once during the 2025 regular session, the appropriation or transfer must be given effect once.

Sec. 7. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit.

Sec. 8. **EFFECTIVE DATE.**

This article is effective July 1, 2025, unless a different effective date is specified.

ARTICLE 15

OTHER AGENCY APPROPRIATIONS

Section 1. **OTHER AGENCY APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **COUNCIL ON DISABILITY**	**$ 2,432,000**	**$ 2,457,000**
Legislative Task Force On Guardianship Funding Cancellation		
Any unencumbered and unexpended amount of the fiscal year 2025 appropriation referenced in Laws 2024, chapter 127, article 53, section 4, for the Legislative Task Force on Guardianship, estimated to be $400,000, is canceled.		
Sec. 3. **OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$ 3,706,000**	**$ 3,765,000**
Sec. 4. **OFFICE OF ADMINISTRATIVE HEARINGS**	**$ 272,000**	**$ 262,000**
Sec. 5. **MINNESOTA HUMANITIES CENTER**	**$ 68,000**	**$ -0-**
YouLead2025		
$68,000 in fiscal year 2026 is for a competitive grant for a youth development and youth		

leadership program focused on inspiring youth to be intercultural ambassadors for positive change in their respective countries. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16B.98, subdivision 14, the Board of Directors of the Minnesota Humanities Center must not use any of the grant amounts for administrative costs.

Sec. 6. **BOARD OF BEHAVIORAL HEALTH AND THERAPY** **$ 2,000 $ 1,000**

The general fund base for this section is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Sec. 7. **BOARD OF MEDICAL PRACTICE** **$ 3,000 $ 1,000**

The general fund base for this section is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Sec. 8. **BOARD OF NURSING** **$ 4,000 $ 2,000**

The general fund base for this section is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Sec. 9. **COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES** **$ 100,000 $ 100,000**

Subdivision 1. **Families and Children Opiate Epidemic Grant to Beltrami County**

$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are for a grant to Beltrami County to support families and children affected by the opiate epidemic who are in the child welfare system or at risk of entering the child welfare system. This is a onetime appropriation.

Subd. 2. **General Fund Base**

The general fund base for this section is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Sec. 10. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation or transfer in this article is enacted more than once during the 2025 regular session, the appropriation or transfer must be given effect once.

Sec. 11. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit.

Sec. 12. **EFFECTIVE DATE.**

This article is effective July 1, 2025, unless a different effective date is specified.

APPENDIX
Article locations for UEH2434-1

144A.071 MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.

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

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

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

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

(3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new beds are transferred from a 45-bed facility in Austin under common ownership that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common ownership; (ii) the commissioner of human services is authorized by the 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii) money is available from planned closures of facilities under common ownership to make implementation of this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's disease or related dementias;

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

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

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

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

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

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

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

(6) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of

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

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

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

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

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

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

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

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

245A.042 HOME AND COMMUNITY-BASED SERVICES; ADDITIONAL STANDARDS AND PROCEDURES.

Subd. 2. **Modified application procedures.** (a) Applicants seeking chapter 245D licensure who meet the following criteria are subject to modified application procedures:

(1) the applicant holds a chapter 245B license issued on or before December 31, 2012, at the time of application;

(2) the applicant's chapter 245B license or licenses are in substantial compliance according to the licensing standards in this chapter and chapter 245B; and

(3) the commissioner has conducted at least one on-site inspection of the chapter 245B license or licenses within the two-year period before submitting the chapter 245D license application.

For purposes of this subdivision, "substantial compliance" means the commissioner has not issued a sanction according to section 245A.07 against any chapter 245B license held by the applicant or made the chapter 245B license or licenses conditional according to section 245A.06 within the 12-month period before submitting the application for chapter 245D licensure.

(b) The modified application procedures mean the commissioner must accept the applicant's attestation of compliance with certain requirements in lieu of providing information to the commissioner for evaluation that is otherwise required when seeking chapter 245D licensure.

Subd. 3. **Implementation.** (a) The commissioner shall implement the responsibilities of this chapter according to the timelines in paragraphs (b) and (c) only within the limits of available appropriations or other administrative cost recovery methodology.

(b) The licensure of home and community-based services according to this section shall be implemented January 1, 2014. License applications shall be received and processed on a phased-in schedule as determined by the commissioner beginning July 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that the application is complete according to section 245A.04.

(c) Within the limits of available appropriations or other administrative cost recovery methodology, implementation of compliance monitoring must be phased in after January 1, 2014.

(1) Applicants who do not currently hold a license issued under chapter 245B must receive an initial compliance monitoring visit after 12 months of the effective date of the initial license for the purpose of providing technical assistance on how to achieve and maintain compliance with the applicable law or rules governing the provision of home and community-based services under chapter 245D. If during the review the commissioner finds that the license holder has failed to achieve compliance with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing review report with recommendations for achieving and maintaining compliance.

(2) Applicants who do currently hold a license issued under this chapter must receive a compliance monitoring visit after 24 months of the effective date of the initial license.

(d) Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend or revoke a license or issue a fine at any time under section 245A.07, or issue correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(e) License holders governed under chapter 245D must ensure compliance with the following requirements within the stated timelines:

(1) service initiation and service planning requirements must be met at the next annual meeting of the person's support team or by January 1, 2015, whichever is later, for the following:

(i) provision of a written notice that identifies the service recipient rights and an explanation of those rights as required under section 245D.04, subdivision 1;

(ii) service planning for basic support services as required under section 245D.07, subdivision 2; and

(iii) service planning for intensive support services under section 245D.071, subdivisions 3 and 4;

(2) staff orientation to program requirements as required under section 245D.09, subdivision 4, for staff hired before January 1, 2014, must be met by January 1, 2015. The license holder may otherwise provide documentation verifying these requirements were met before January 1, 2014;

(3) development of policy and procedures as required under section 245D.11, must be completed no later than August 31, 2014;

(4) written or electronic notice and copies of policies and procedures must be provided to all persons or their legal representatives and case managers as required under section 245D.10, subdivision 4, paragraphs (b) and (c), by September 15, 2014, or within 30 days of development of the required policies and procedures, whichever is earlier; and

(5) all employees must be informed of the revisions and training must be provided on implementation of the revised policies and procedures as required under section 245D.10, subdivision 4, paragraph (d), by September 15, 2014, or within 30 days of development of the required policies and procedures, whichever is earlier.

Subd. 4. **Stakeholder consultation.** The commissioner shall consult with the existing stakeholder group established as part of the provider standards process to gather input related to the development of an administrative cost recovery methodology to implement the provisions in chapter 245D.

245G.01 DEFINITIONS.

Subd. 20d. **Skilled treatment services.** "Skilled treatment services" has the meaning provided in section 254B.01, subdivision 10.

245G.07 TREATMENT SERVICE.

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner;

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

(8) peer recovery support services must be provided by a recovery peer qualified according to section 245I.04, subdivision 18. Peer recovery support services must be provided according to sections 254B.05, subdivision 5, and 254B.052.

246B.01 MINNESOTA SEX OFFENDER PROGRAM; DEFINITIONS.

Subd. 2. **Executive board.** "Executive board" has the meaning given in section 246C.015.

246C.015 DEFINITIONS.

Subd. 5a. **Direct Care and Treatment.** "Direct Care and Treatment" means the agency of Direct Care and Treatment established under this chapter.

Subd. 6. **Executive board.** "Executive board" means the Direct Care and Treatment executive board established under section 246C.06.

246C.06 EXECUTIVE BOARD; MEMBERSHIP; GOVERNANCE.

Subdivision 1. **Establishment.** The Direct Care and Treatment executive board is established.

Subd. 2. **Membership.** (a) The Direct Care and Treatment executive board consists of nine members with seven voting members and two nonvoting members. The seven voting members must include six members appointed by the governor with the advice and consent of the senate in accordance with paragraph (b) and the commissioner of human services or a designee. The two nonvoting members must be appointed in accordance with paragraph (c). Section 15.0597 applies to all executive board appointments except for the commissioner of human services.

(b) The executive board voting members appointed by the governor must meet the following qualifications:

(1) one member must be a licensed physician who is a psychiatrist or has experience in serving behavioral health patients;

(2) two members must have experience serving on a hospital or nonprofit board; and

(3) three members must have experience working: (i) in the delivery of behavioral health services or care coordination or in traditional healing practices; (ii) as a licensed health care professional; (iii) within health care administration; or (iv) with residential services.

(c) The executive board nonvoting members must be appointed as follows:

(1) one member appointed by the Association of Counties; and

(2) one member who has an active role as a union representative representing staff at Direct Care and Treatment appointed by joint representatives of the following unions: American Federation of State, County and Municipal Employees (AFSCME); Minnesota Association of Professional Employees (MAPE); Minnesota Nurses Association (MNA); Middle Management Association (MMA); and State Residential Schools Education Association (SRSEA).

(d) Membership on the board must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

(e) A voting member of the executive board must not be or must not have been within one year prior to appointment: (1) an employee of Direct Care and Treatment; (2) an employee of a county, including a county commissioner; (3) an active employee or representative of a labor union that represents employees of Direct Care and Treatment; or (4) a member of the state legislature. This

paragraph does not apply to the nonvoting members or the commissioner of human services or designee.

Subd. 3. **Procedures.** Except as otherwise provided in this section, the membership terms and removal and filling of vacancies for the executive board are governed by section 15.0575.

Subd. 4. **Compensation.** (a) Notwithstanding section 15.0575, subdivision 3, paragraph (a), the nonvoting members of the executive board must not receive daily compensation for executive board activities. Nonvoting members of the executive board may receive expenses in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. Nonvoting members who, as a result of time spent attending board meetings, incur child care expenses that would not otherwise have been incurred may be reimbursed for those expenses upon board authorization.

(b) Notwithstanding section 15.0575, subdivision 3, paragraph (a), the Compensation Council under section 15A.082 must determine the compensation for voting members of the executive board per day spent on executive board activities authorized by the executive board. Voting members of the executive board may also receive the expenses in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. Voting members who, as a result of time spent attending board meetings, incur child care expenses that would not otherwise have been incurred may be reimbursed for those expenses upon board authorization.

(c) The commissioner of management and budget must publish the daily compensation rate for voting members of the executive board determined under paragraph (b) on the Department of Management and Budget's website.

(d) Voting members of the executive board must adopt internal standards prescribing what constitutes a day spent on board activities for the purposes of making payments authorized under paragraph (b).

(e) All other requirements under section 15.0575, subdivision 3, apply to the compensation of executive board members.

Subd. 5. **Acting chair; officers.** (a) The governor shall designate one member from the voting membership appointed by the governor as acting chair of the executive board.

(b) At the first meeting of the executive board, the executive board must elect a chair from among the voting membership appointed by the governor.

(c) The executive board must annually elect a chair from among the voting membership appointed by the governor.

(d) The executive board must elect officers from among the voting membership appointed by the governor. The elected officers shall serve for one year.

Subd. 6. **Terms.** (a) Except for the commissioner of human services, executive board members must not serve more than two consecutive terms unless service beyond two consecutive terms is approved by the majority of voting members. The commissioner of human services or a designee shall serve until replaced by the governor.

(b) An executive board member may resign at any time by giving written notice to the executive board.

(c) The initial term of the member appointed under subdivision 2, paragraph (b), clause (1), is two years. The initial term of the members appointed under subdivision 2, paragraph (b), clause (2), is three years. The initial term of the members appointed under subdivision 2, paragraph (b), clause (3), and the members appointed under subdivision 2, paragraph (c), is four years.

(d) After the initial term, the term length of all appointed executive board members is four years.

Subd. 7. **Conflicts of interest.** Executive board members must recuse themselves from discussion of and voting on an official matter if the executive board member has a conflict of interest. A conflict of interest means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an executive board member's decision in matters related to Direct Care and Treatment or the conduct of activities under this chapter.

Subd. 8. **Meetings.** The executive board must meet at least four times per fiscal year at a place and time determined by the executive board.

Subd. 9. **Quorum.** A majority of the voting members of the executive board constitutes a quorum. The affirmative vote of a majority of the voting members of the executive board is necessary and sufficient for action taken by the executive board.

Subd. 10. **Immunity; indemnification.** (a) Members of the executive board are immune from civil liability for any act or omission occurring within the scope of the performance of their duties under this chapter.

(b) When performing executive board duties or actions, members of the executive board are employees of the state for purposes of indemnification under section 3.736, subdivision 9.

246C.07 POWERS AND DUTIES OF EXECUTIVE BOARD.

Subd. 4. **Creation of bylaws.** The board may establish bylaws governing its operations and the operations of Direct Care and Treatment in accordance with this chapter.

Subd. 5. **Performance of chief executive officer.** The governor may request that the executive board review the performance of the chief executive officer at any time. Within 14 days of receipt of the request, the board must meet and conduct a performance review as specifically requested by the governor. During the performance review, a representative of the governor must be included as a voting member of the board for the purpose of the board's discussions and decisions regarding the governor's request. The board must establish a performance improvement plan as necessary or take disciplinary or other corrective action, including dismissal. The executive board must report to the governor on action taken by the board, including an explanation if no action is deemed necessary.

252.021 DEFINITION.

Subd. 2. **Executive board.** "Executive board" has the meaning given in section 246C.015.

253.195 DEFINITIONS.

Subd. 2. **Executive board.** "Executive board" has the meaning given in section 246C.015.

253B.02 DEFINITIONS.

Subd. 7b. **Executive board.** "Executive board" has the meaning given in section 246C.015.

253D.02 DEFINITIONS.

Subd. 7a. **Executive board.** "Executive board" has the meaning given under section 246C.015.

254B.01 DEFINITIONS.

Subd. 5. **Local agency.** "Local agency" means the agency designated by a board of county commissioners, a local social services agency, or a human services board authorized under section 254B.03, subdivision 1, to determine financial eligibility for the behavioral health fund.

Subd. 15. **Executive board.** "Executive board" has the meaning given in section 246C.015.

254B.18 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) opiate antagonist 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.

(c) The commissioner must prioritize grant applications for organizations that are culturally specific or culturally responsive and that commit to serving individuals from communities that are disproportionately impacted by the opioid epidemic, including:

(1) Native American, American Indian, and Indigenous communities; and

(2) Black, African American, and African-born communities.

(d) For purposes of this section, a "culturally specific" or "culturally responsive" organization is an organization that is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background, and is governed with significant input from individuals of that specific background.

256.045 ADMINISTRATIVE AND JUDICIAL REVIEW OF HUMAN SERVICES MATTERS.

Subd. 1a. **Direct Care and Treatment executive board or executive board.** For purposes of this section, "Direct Care and Treatment executive board" or "executive board" means the Direct Care and Treatment executive board established under section 246C.06.

256B.0949 EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT.

Subd. 9. **Revision of treatment modalities.** (a) The commissioner may revise covered treatment modalities as needed based on outcome data and other evidence. EIDBI treatment modalities approved by the department must:

(1) cause no harm to the person or the person's family;

(2) be individualized and person-centered;

(3) be developmentally appropriate and highly structured, with well-defined goals and objectives that provide a strategic direction for treatment;

(4) be based in recognized principles of developmental and behavioral science;

(5) utilize sound practices that are replicable across providers and maintain the fidelity of the specific modality;

(6) demonstrate an evidentiary basis;

(7) have goals and objectives that are measurable, achievable, and regularly evaluated and adjusted to ensure that adequate progress is being made;

(8) be provided intensively with a high staff-to-person ratio; and

(9) include participation by the person and the person's legal representative in decision making, knowledge building and capacity building, and developing and implementing the person's ITP.

(b) Before revisions in department recognized treatment modalities become effective, the commissioner must provide public notice of the changes, the reasons for the change, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's website.

256G.02 DEFINITIONS.

Subd. 5a. **Direct Care and Treatment executive board or executive board.** "Direct Care and Treatment executive board" or "executive board" means the Direct Care and Treatment executive board established under section 246C.06.

256R.02 DEFINITIONS.

Subd. 38. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on December 31, 2015, under Minnesota Rules and Minnesota Statutes, inclusive of health insurance, plus property insurance costs from external fixed costs, minus any rate increases allowed under Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 55a.

256R.12 COST ALLOCATION.

Subd. 10. **Allocation of self-insurance costs.** For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health, dental, or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this chapter. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or those self-insurance costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its group health, dental, or life insurance self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs.

256R.23 TOTAL CARE-RELATED PAYMENT RATES.

Subd. 6. **Payment rate limit reduction.** No facility shall be subject in any rate year to a care-related payment rate limit reduction greater than five percent of the median determined in subdivision 4.

256R.36 HOLD HARMLESS.

No nursing facility's operating payment rate, plus its employer health insurance costs portion of the external fixed costs payment rate, will be less than its prior system operating cost payment rate.

256R.40 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility or the date that beds from a partial closure are delicensed and decertified.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. **Applications for planned closure rate.** (a) To be considered for approval of a planned closure, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan designed to comply with section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided; and

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

(b) The application must also address the criteria listed in subdivision 3.

Subd. 3. **Criteria for review of application.** In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area. The facility shall indicate in its application the service area it believes is appropriate for this measurement;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 4. **Review and approval of applications.** (a) The commissioner, in consultation with the commissioner of health, shall approve or deny an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner unless commencement of closure has begun.

(c) The commissioner may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs immediately following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

Subd. 6. **Assignment of closure rate to another facility.** A facility or facilities reimbursed under this chapter with a closure plan approved by the commissioner under subdivision 4 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 5. Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 5, unless they: (1) are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater; (2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and (3) have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 5 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 5, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 5, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that delicensed beds is located.

Subd. 7. **Other rate adjustments.** Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under this chapter.

256R.41 SINGLE-BED ROOM INCENTIVE.

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on either the first day of the month of January or July, whichever occurs first following the date of the bed delicensure.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

256R.481 RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.

(a) The commissioner shall allow each nonprofit nursing facility located within the boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once annually for a rate add-on to the facility's external fixed costs payment rate.

(b) A facility seeking an add-on to its external fixed costs payment rate under this section must apply annually to the commissioner to receive the add-on. A facility must submit the application

within 60 calendar days of the effective date of any add-on under this section. The commissioner may waive the deadlines required by this paragraph under extraordinary circumstances.

(c) The commissioner shall provide the add-on to each eligible facility that applies by the application deadline.

(d) The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for case mix classification PA1 of the nonprofit facilities located in an adjacent city in another state and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment rate for case mix classification PA1 as determined under section 256R.22, subdivision 4.

256S.205 CUSTOMIZED LIVING SERVICES; DISPROPORTIONATE SHARE RATE ADJUSTMENTS.

Subd. 7. **Expiration.** This section expires January 1, 2026.

Laws 2023, chapter 59, article 3, section 11

Sec. 11. **DIRECT CARE PROVIDER PREMIUMS THROUGH HCBS WORKFORCE INCENTIVE FUND.**

(a) $20,000,000 in fiscal year 2026 is added to the base appropriation from the family and medical benefit account to the commissioner of human services to provide reimbursement for premiums incurred for the paid family and medical leave program under this chapter. Funds shall be administered through the home and community-based workforce incentive fund under Minnesota Statutes, section 256.4764.

(b) The commissioner of employment and economic development shall share premium payment data collected under this chapter to assist the commissioner of human services in the verification process of premiums paid under this section.

(c) This amount is for the purposes of Minnesota Statutes, section 256.4764. This is a one-time appropriation and is available until June 30, 2027.

Laws 2024, chapter 125, article 5, section 40

Sec. 40. **DIRECT CARE AND TREATMENT ADVISORY COMMITTEE.**

(a) The Direct Care and Treatment executive board under Minnesota Statutes, section 246C.07, shall establish an advisory committee to provide state legislators, counties, union representatives, the National Alliance on Mental Illness Minnesota, people being served by direct care and treatment programs, and other stakeholders the opportunity to advise the executive board regarding the operation of Direct Care and Treatment.

(b) The members of the advisory committee must be appointed as follows:

(1) one member appointed by the speaker of the house;

(2) one member appointed by the minority leader of the house of representatives;

(3) two members appointed by the senate Committee on Committees, one member representing the majority caucus and one member representing the minority caucus;

(4) one member appointed by the Association of Minnesota Counties;

(5) one member appointed by joint representatives of the American Federation of State and Municipal Employees, the Minnesota Association of Professional Employees, the Minnesota Nurses Association, the Middle Management Association, and the State Residential Schools Education Association;

(6) one member appointed by the National Alliance on Mental Illness Minnesota; and

(7) two members representing people with lived experience being served by state-operated treatment programs or their families, appointed by the governor.

(c) Appointing authorities under paragraph (b) shall make appointments by January 1, 2026.

(d) The first meeting of the advisory committee must be held no later than January 15, 2026. The members of the advisory committee shall elect a chair from among their membership at the first meeting. The advisory committee shall meet as frequently as it determines necessary.

(e) The executive board shall regularly consult with the advisory committee.

(f) The advisory committee under this section expires December 31, 2027.

Laws 2024, chapter 125, article 5, section 41

Sec. 41. **INITIAL APPOINTMENTS AND COMPENSATION OF THE DIRECT CARE AND TREATMENT EXECUTIVE BOARD AND CHIEF EXECUTIVE OFFICER.**

Subdivision 1. **Executive board.** (a) The initial appointments of the members of the Direct Care and Treatment executive board under Minnesota Statutes, section 246C.06, must be made by January 1, 2025.

(b) Prior to the first Compensation Council determination of the daily compensation rate for voting members of the executive board under Minnesota Statutes, section 246C.06, subdivision 4,

paragraph (b), voting members of the executive board must be paid the per diem rate provided for in Minnesota Statutes, section 15.0575, subdivision 3, paragraph (a).

(c) The executive board is exempt from Minnesota Statutes, section 13D.01, until the authority and responsibilities for Direct Care and Treatment are transferred to the executive board in accordance with Minnesota Statutes, section 246C.04.

Subd. 2. **Chief executive officer.** (a) The Direct Care and Treatment executive board must appoint as the initial chief executive officer for Direct Care and Treatment under Minnesota Statutes, section 246C.07, the chief executive officer of the direct care and treatment division of the Department of Human Services holding that position at the time the initial appointment is made by the board. The initial appointment of the chief executive officer must be made by the executive board by July 1, 2025. The initial appointment of the chief executive officer is subject to confirmation by the senate.

(b) In its report issued April 1, 2025, the Compensation Council under Minnesota Statutes, section 15A.082, must establish the salary of the chief executive officer at an amount equal to or greater than the amount paid to the chief executive officer of the direct care and treatment division of the Department of Human Services as of the date of initial appointment. The salary of the chief executive officer shall become effective July 1, 2025, pursuant to Minnesota Statutes, section 15A.082, subdivision 3. Notwithstanding Minnesota Statutes, sections 15A.082 and 246C.08, subdivision 1, if the initial appointment of the chief executive officer occurs prior to the effective date of the salary specified by the Compensation Council in its April 1, 2025, report, the salary of the chief executive officer must equal the amount paid to the chief executive officer of the direct care and treatment division of the Department of Human Services as of the date of initial appointment.

Subd. 3. **Commissioner of human services to consult.** In preparing the budget estimates required under Minnesota Statutes, section 16A.10, for the direct care and treatment division for the 2026-2027 biennial budget and any legislative proposals for the 2025 legislative session that involve direct care and treatment operations, the commissioner of human services must consult with the Direct Care and Treatment executive board before submitting the budget estimates or legislative proposals. If the executive board is not appointed by the date the budget estimates must be submitted to the commissioner of management and budget, the commissioner of human services must provide the executive board with a summary of the budget estimates that were submitted.

EFFECTIVE DATE. This section is effective July 1, 2024.
Laws 2024, chapter 127, article 46, section 39

Sec. 39. **LEGISLATIVE TASK FORCE ON GUARDIANSHIP.**

Subdivision 1. **Membership.** (a) The Legislative Task Force on Guardianship consists of the following members:

(1) one member of the house of representatives, appointed by the speaker of the house of representatives;

(2) one member of the house of representatives, appointed by the minority leader of the house of representatives;

(3) one member of the senate, appointed by the senate majority leader;

(4) one member of the senate, appointed by the senate minority leader;

(5) one judge who has experience working on guardianship cases, appointed by the chief justice of the supreme court;

(6) two individuals presently or formerly under guardianship or emergency guardianship, appointed by the Minnesota Council on Disability;

(7) one private, professional guardian, appointed by the Minnesota Council on Disability;

(8) one private, nonprofessional guardian, appointed by the Minnesota Council on Disability;

(9) one representative of the Department of Human Services with knowledge of public guardianship issues, appointed by the commissioner of human services;

(10) one member appointed by the Minnesota Council on Disability;

(11) two members of two different disability advocacy organizations, appointed by the Minnesota Council on Disability;

(12) one member of a professional or advocacy group representing the interests of the guardian who has experience working in the judicial system on guardianship cases, appointed by the Minnesota Council on Disability;

(13) one member of a professional or advocacy group representing the interests of persons subject to guardianship who has experience working in the judicial system on guardianship cases, appointed by the Minnesota Council on Disability;

(14) two members of two different advocacy groups representing the interests of older Minnesotans who are or may find themselves subject to guardianship, appointed by the Minnesota Council on Disability;

(15) one employee acting as the Disability Systems Planner in the Center for Health Equity at the Minnesota Department of Health, appointed by the commissioner of health;

(16) one member appointed by the Minnesota Indian Affairs Council;

(17) one member from the Commission of the Deaf, Deafblind, and Hard-of-Hearing, appointed by the executive director of the commission;

(18) one member of the Council on Developmental Disabilities, appointed by the executive director of the council;

(19) one employee from the Office of Ombudsman for Mental Health and Developmental Disabilities, appointed by the ombudsman;

(20) one employee from the Office of Ombudsman for Long Term Care, appointed by the ombudsman;

(21) one member appointed by the Minnesota Association of County Social Services Administrators (MACSSA);

(22) one employee from the Olmstead Implementation Office, appointed by the director of the office; and

(23) one member representing an organization dedicated to supported decision-making alternatives to guardianship, appointed by the Minnesota Council on Disability.

(b) Appointees to the task force must be named by each appointing authority by June 30, 2025. Appointments made by an agency or commissioner may also be made by a designee.

(c) The member from the Minnesota Council on Disability serves as chair of the task force. The chair must designate a member to serve as secretary.

Subd. 2. **Meetings; administrative support.** The first meeting of the task force must be convened by the chair no later than September 1, 2025, if an appropriation is made by that date for the task force. The task force must meet at least quarterly. Meetings are subject to Minnesota Statutes, chapter 13D. The task force may meet by telephone or interactive technology consistent with Minnesota Statutes, section 13D.015. The Minnesota Council on Disability shall provide meeting space and administrative and research support to the task force.

Subd. 3. **Duties.** (a) The task force must make recommendations to address concerns and gaps related to guardianships and less restrictive alternatives to guardianships in Minnesota, including but not limited to:

(1) developing efforts to sustain and increase the number of qualified guardians;

(2) increasing compensation for in forma pauperis (IFP) guardians by studying current funding streams to develop approaches to ensure that the funding streams are consistent across the state and sufficient to serve the needs of persons subject to guardianship;

(3) securing ongoing funding for guardianships and less restrictive alternatives;

(4) establishing guardian certification or licensure;

(5) identifying standards of practice for guardians and options for providing education to guardians on standards and less restrictive alternatives;

(6) securing ongoing funding for the guardian and conservator administrative complaint process;

(7) identifying and understanding alternatives to guardianship whenever possible to meet the needs of patients and the challenges of providers in the delivery of health care, behavioral health care, and residential and home-based care services;

(8) expanding supported decision-making alternatives to guardianships and conservatorships;

(9) reducing the removal of civil rights when appointing a guardian, including by ensuring guardianship is only used as a last resort; and

(10) identifying ways to preserve and to maximize the civil rights of the person, including due process considerations.

(b) The task force must seek input from the public, the judiciary, people subject to guardianship, guardians, advocacy groups, and attorneys. The task force must hold hearings to gather information to fulfill the purpose of the task force.

Subd. 4. **Compensation; expenses.** Members of the task force may receive compensation and expense reimbursement as provided in Minnesota Statutes, section 15.059, subdivision 3.

Subd. 5. **Report; expiration.** The task force shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over guardianship issues no later than January 15, 2027. The report must describe any concerns about the current guardianship system identified by the task force and recommend policy options to address those concerns and to promote less restrictive alternatives to guardianship. The report must include draft legislation to implement recommended policy.

Subd. 6. **Expiration.** The task force expires upon submission of its report, or January 16, 2027, whichever is earlier.

EFFECTIVE DATE. This section is effective the day following final enactment.
Laws 2024, chapter 127, article 50, section 40

Sec. 40. **DIRECT CARE AND TREATMENT ADVISORY COMMITTEE.**

(a) The Direct Care and Treatment executive board under Minnesota Statutes, section 246C.07, shall establish an advisory committee to provide state legislators, counties, union representatives, the National Alliance on Mental Illness Minnesota, people being served by direct care and treatment programs, and other stakeholders the opportunity to advise the executive board regarding the operation of Direct Care and Treatment.

(b) The members of the advisory committee must be appointed as follows:

(1) one member appointed by the speaker of the house;

(2) one member appointed by the minority leader of the house of representatives;

(3) two members appointed by the senate Committee on Committees, one member representing the majority caucus and one member representing the minority caucus;

(4) one member appointed by the Association of Minnesota Counties;

(5) one member appointed by joint representatives of the American Federation of State and Municipal Employees, the Minnesota Association of Professional Employees, the Minnesota Nurses Association, the Middle Management Association, and the State Residential Schools Education Association;

(6) one member appointed by the National Alliance on Mental Illness Minnesota; and

(7) two members representing people with lived experience being served by state-operated treatment programs or their families, appointed by the governor.

(c) Appointing authorities under paragraph (b) shall make appointments by January 1, 2026.

(d) The first meeting of the advisory committee must be held no later than January 15, 2026. The members of the advisory committee shall elect a chair from among their membership at the first meeting. The advisory committee shall meet as frequently as it determines necessary.

(e) The executive board shall regularly consult with the advisory committee.

(f) The advisory committee under this section expires December 31, 2027.
Laws 2024, chapter 127, article 50, section 41 Subdivisions 1, 3,

Sec. 41. **INITIAL APPOINTMENTS AND COMPENSATION OF THE DIRECT CARE AND TREATMENT EXECUTIVE BOARD AND CHIEF EXECUTIVE OFFICER.**

Subdivision 1. **Executive board.** (a) The initial appointments of the members of the Direct Care and Treatment executive board under Minnesota Statutes, section 246C.06, must be made by January 1, 2025.

(b) Prior to the first Compensation Council determination of the daily compensation rate for voting members of the executive board under Minnesota Statutes, section 246C.06, subdivision 4, paragraph (b), voting members of the executive board must be paid the per diem rate provided for in Minnesota Statutes, section 15.0575, subdivision 3, paragraph (a).

(c) The executive board is exempt from Minnesota Statutes, section 13D.01, until the authority and responsibilities for Direct Care and Treatment are transferred to the executive board in accordance with Minnesota Statutes, section 246C.04.

Subd. 3. **Commissioner of human services to consult.** In preparing the budget estimates required under Minnesota Statutes, section 16A.10, for the direct care and treatment division for the 2026-2027 biennial budget and any legislative proposals for the 2025 legislative session that involve direct care and treatment operations, the commissioner of human services must consult with the Direct Care and Treatment executive board before submitting the budget estimates or legislative proposals. If the executive board is not appointed by the date the budget estimates must be submitted to the commissioner of management and budget, the commissioner of human services must provide the executive board with a summary of the budget estimates that were submitted.
Laws 2024, chapter 79, article 1, section 20

Sec. 20. Minnesota Statutes 2023 Supplement, section 246C.03, subdivision 2, is amended to read:

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, serving as a public sector labor union representative, experience in delivery of behavioral health services or care coordination, or working as a licensed health care provider, in an allied health profession, or in health care administration.~~