State of Minnesota

HOUSE OF REPRESENTATIVES

SPECIAL SESSION

H. F. No. 3

06/09/2025 Authored by Noor and Schomacker
The bill was read for the first time
R/S Rules Suspended, urgency declared
Read for the Second Time
Read for the Third Time
Passed by the House and transmitted to the Senate
Passed by the Senate and returned to the House
06/12/2025 Presented to Governor
06/14/2025 Governor Approval

A bill for an act

relating to human services; amending provisions on aging and older adult services, disability services, health care, substance use disorder treatment, Direct Care and Treatment, early intensive developmental and behavioral intervention program reform, homelessness, and the Department of Health; making technical and conforming changes; establishing task forces; requiring reports; making forecast adjustments; appropriating money; amending Minnesota Statutes 2024, sections 144.0724, subdivision 11, as amended; 144A.01, subdivision 4; 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; 181.213, subdivision 2, by adding subdivisions; 245.735, subdivision 3; 245.91, subdivision 4, as amended; 245A.03, by adding a subdivision; 245A.04, subdivision 7, as amended; 245A.042, by adding subdivisions; 245A.043, by adding a subdivision; 245A.06, subdivisions 1a, 2; 245A.10, subdivisions 1, 2, 3, 4, 8, by adding subdivisions; 245C.03, subdivisions 6, 15, by adding a subdivision; 245C.04, subdivision 6, by adding subdivisions; 245C.10, subdivision 6, by adding a subdivision; 245C.13, subdivision 2; 245C.16, subdivision 1; 245D.091, subdivisions 2, as amended, 3, as amended; 245F.08, subdivision 3; 245G.01, subdivision 13b, by adding subdivisions; 245G.02, subdivision 2; 245G.07, subdivisions 1, 3, 4, by adding subdivisions; 245G.11, subdivision 6, by adding a subdivision; 245G.22, subdivisions 11, 15, as amended; 246.54, subdivisions 1a, 1b; 246C.07, by adding a subdivision; 252.32, subdivision 3; 253B.10, subdivision 1, as amended; 254A.19, subdivision 4; 254B.01, subdivisions 10, 11; 254B.02, subdivision 5; 254B.03, subdivisions 1, 3; 254B.04, subdivisions 1a, as amended, 5, 6, 6a; 254B.05, subdivisions 1, as amended, 1a, as amended, 5, as amended, by adding a subdivision; 254B.052, by adding a subdivision; 254B.09, subdivision 2; 254B.19, subdivision 1; 256.01, by adding a subdivision; 256.043, subdivision 3; 256.476, subdivision 4; 256.4792; 256.9657, subdivision 1; 256.9752, subdivisions 2, 3; 256B.04, subdivision 21; 256B.051, subdivisions 2, 5, 6, 8, by adding subdivisions; 256B.0625, subdivision 5m, as amended; 256B.0659, subdivision 17a; 256B.0701, subdivisions 1, 2, by adding subdivisions; 256B.0757, subdivision 4c; 256B.0911, subdivisions 1, 10, 13, 14, 17, 24, 30, by adding subdivisions; 256B.092, subdivisions 1a, as amended, 3, by adding a subdivision; 256B.0924, subdivision 6; 256B.0949, subdivisions 2, 13, 15, 16, 16a, by adding a subdivision; 256B.431, subdivision 30; 256B.434, subdivisions 4, 4k; 256B.49, subdivisions 13, as amended, 18, by adding a subdivision; 256B.4914, subdivisions 3, 5, 5a, 5b, 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.08, subdivisions 1, 2; 256G.09, subdivisions 1, 2, as amended; 256I.04, subdivision 2a; 256I.05, by adding subdivisions; 256R.02, by adding subdivisions; 256R.23, subdivisions 7, 8; 256R.24, subdivision 3; 256R.25, as amended; 256R.26, subdivision 9; 256R.27, subdivisions 2, 3; 256R.41; 256R.43; 256S.205, subdivisions 2, 3, 5, 7, by adding subdivisions; 260E.14, subdivision 1, as amended; 325F.725; 611.43, by adding a subdivision; 626.5572, subdivision 13; Laws 2021, First Special Session chapter 7, article 13, section 73; Laws 2023, chapter 61, article 1, section 61, subdivision 4; article 9, section 2, subdivisions 13, 14, as amended, 16, as amended, 17, 18, as amended; Laws 2024, chapter 125, article 4, section 9, subdivisions 1, 8, 9, by adding a subdivision; article 6, section 1, subdivision 7; article 8, section 2, subdivisions 12, 13, 14, 15, 19; proposing coding for new law in Minnesota Statutes, chapters 145D; 245A; 245D; 254B; 256B; 256R; repealing Minnesota Statutes 2024, sections 245C.03, subdivision 13; 245C.10, subdivision 16; 245G.01, subdivision 20d; 245G.07, subdivision 2; 254B.01, subdivision 5; 254B.04, subdivision 2a; 254B.181; 256B.0949, subdivision 9; 256R.02, subdivision 38; 256R.12, subdivision 10; 256R.23, subdivision 6; 256R.36; Laws 2021, First Special Session chapter 7, article 13, section 75, subdivisions 3, as amended, 6, as amended; Laws 2023, chapter 59, article 3, section 11; Laws 2024, chapter 127, article 46, section 39.

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

ARTICLE 1

AGING AND OLDER ADULT SERVICES

Section 1. Minnesota Statutes 2024, section 181.213, subdivision 2, is amended to read:

Subd. 2. **Investigation of market conditions.** (a) The board must investigate market conditions and the existing wages, benefits, and working conditions of nursing home workers for specific geographic areas of the state and specific nursing home occupations. Based on this information, the board must seek to adopt minimum nursing home employment standards that meet or exceed existing industry conditions for a majority of nursing home workers in the relevant geographic area and nursing home occupation. Except for standards exceeding the threshold determined in paragraph (d), initial employment standards established by the board are effective beginning January 1, 2025, and shall remain in effect until any subsequent standards are adopted by rules.

(b) The board must consider the following types of information in making determinations that employment standards are reasonably necessary to protect the health and welfare of nursing home workers:

(1) wage rate and benefit data collected by or submitted to the board for nursing home workers in the relevant geographic area and nursing home occupations;

(2) statements showing wage rates and benefits paid to nursing home workers in the relevant geographic area and nursing home occupations;

(3) signed collective bargaining agreements applicable to nursing home workers in the relevant geographic area and nursing home occupations;

(4) testimony and information from current and former nursing home workers, worker organizations, nursing home employers, and employer organizations;

(5) local minimum nursing home employment standards;

(6) information submitted by or obtained from state and local government entities; and

(7) any other information pertinent to establishing minimum nursing home employment standards.

(c) In considering wage and benefit increases, the board must determine the impact of the proposed standards on nursing home operating payment rates determined pursuant to section 256R.21, subdivision 3, and the employee benefits portion of the external fixed costs payment rate determined pursuant to section 256R.25. If the board, in consultation with the commissioner of human services, determines the operating payment rate and employee benefits portion of the external fixed costs payment rate will increase to comply with the new employment standards, the board shall report to the legislature the increase in funding needed to increase payment rates to comply with the new employment standards and must make implementation of any new nursing home employment standards contingent upon an appropriation, as determined by sections 256R.21 and 256R.25, to fund the rate increase necessary to comply with the new employment standards.

(d) In evaluating the impact of the employment standards on payment rates determined by sections 256R.21 and 256R.25, the board, in consultation with the commissioner of human services, must consider the following:

(1) the statewide average wage rates for employees pursuant to section 256R.10, subdivision 5, and benefit rates pursuant to section 256R.02, subdivisions 18 and 22, as determined by the annual Medicaid cost report used to determine the operating payment rate and the employee benefits portion of the external fixed costs payment rate for the first day of the calendar year immediately following the date the board has established minimum wage and benefit levels;

(2) compare the results of clause (1) to the operating payment rate and employee benefits portion of the external fixed costs payment rate increase for the first day of the second calendar year after the adoption of any nursing home employment standards included in the most recent budget and economic forecast completed under section 16A.103; and

(3) if the established nursing home employment standards result in an increase in costs that exceed the operating payment rate and external fixed costs payment rate increase included in the most recent budget and economic forecast completed under section 16A.103, effective on the proposed implementation date of the new nursing home employment standards, the board must determine if the rates will need to be increased to meet the new employment standards ~~and the standards must not be effective until an appropriation sufficient to cover the rate increase and federal approval of the rate increase is obtained~~.

(e) The budget and economic forecasts completed under section 16A.103 shall not assume an increase in payment rates determined under chapter 256R resulting from the new employment standards until the board certifies the rates will need to be increased and the legislature appropriates funding for the increase in payment rates.

Sec. 2. Minnesota Statutes 2024, section 181.213, is amended by adding a subdivision to read:

Subd. 2a. **Effective dates of new employment standards.** (a) New employment standards that do not meet the threshold determined in subdivision 2, paragraph (c) or (d), are effective on the date determined by the board in rules.

(b) New employment standards that exceed the threshold determined in subdivision 2, paragraph (c) or (d), are effective upon federal approval or the following date, whichever is later:

(1) if subdivision 2b is in effect, the date the applicable rate adjustment under section 256R.495 is effective; or

(2) if subdivision 2b is not in effect, the effective date of an enacted appropriation sufficient to cover the rate increase.

Sec. 3. Minnesota Statutes 2024, section 181.213, is amended by adding a subdivision to read:

Subd. 2b. **Implementation of rate increases.** (a) This paragraph is effective only for those rate years, as defined in section 256R.02, during which both the CPI-U inflation limits and the percentage increase limits under sections 256R.23, subdivisions 7 and 8, and 256R.24, subdivision 3, are in effect.

(b) For an increase in rates the board has determined under subdivision 2, paragraph (c) or (d), is needed to cover the increased cost of compliance with new nursing home

employment standards, the appropriation sufficient to cover the rate increase must be made in the form of a rate adjustment under section 256R.495.

Sec. 4. Minnesota Statutes 2024, section 256.4792, is amended to read:

256.4792 LONG-TERM SERVICES AND SUPPORTS LOAN PROGRAM.

Subdivision 1. **Long-term services and supports loan program.** The commissioner of human services shall establish a ~~competitive~~ loan program to provide operating loans to eligible long-term services and supports providers ~~and facilities~~. The commissioner shall initiate the application process for the loan described in this section ~~at least once annually if money is available. A second application process may be initiated each year at the discretion of the commissioner~~ on an ongoing basis.

Subd. 2. **Eligibility.** To be an eligible applicant for a loan under this section, a provider must submit to the commissioner of human services a loan application in the form and according to the timelines established by the commissioner. In its loan application, a loan applicant must demonstrate the following:

~~(1) for nursing facilities with a medical assistance provider agreement that are licensed as a nursing home or boarding care home according to section 256R.02, subdivision 33:~~

~~(i) the total net income of the nursing facility is not generating sufficient revenue to cover the nursing facility's operating expenses;~~

~~(ii) the nursing facility is at risk of closure; and~~

~~(iii) additional operating revenue is necessary to either preserve access to nursing facility services within the community or support people with complex, high-acuity support needs; and~~

~~(2) for other long-term services and supports providers:~~

~~(i) demonstration~~ (1) that the provider is enrolled in a Minnesota health care program and provides one or more of the following services in a Minnesota health care program:

~~(A)~~ (i) home and community-based services under chapter 245D;

~~(B)~~ (ii) personal care assistance services under section 256B.0659;

~~(C)~~ (iii) community first services and supports under section 256B.85;

~~(D)~~ (iv) early intensive developmental and behavioral intervention services under section 256B.0949;

~~(E)~~ (v) home care services as defined under section 256B.0651, subdivision 1, paragraph (d); or

~~(F)~~ (vi) customized living services as defined in section 256S.02; and

~~(ii)~~ (2) additional operating revenue is necessary to preserve access to services within the community, expand services to people within the community, expand services to new communities, or support people with complex, high-acuity support needs.

Subd. 2a. **Allowable uses of loan money.** ~~(a) A loan awarded to a nursing facility under subdivision 2, clause (1), must only be used to cover the facility's short-term operating expenses. Nursing facilities receiving loans must not use the loan proceeds to pay related organizations as defined in section 256R.02, subdivision 43.~~

~~(b)~~ A loan awarded to a long-term services and supports provider under subdivision 2~~,~~ ~~clause (2),~~ must only be used to cover expenses related to achieving outcomes identified in subdivision 2, clause (2)~~, item (ii)~~.

Subd. 3. **Approving loans.** The commissioner must evaluate all loan applications ~~on a competitive basis~~ and award loans to successful applicants within available appropriations for this purpose. The commissioner's decisions are final and not subject to appeal.

Subd. 4. **Disbursement schedule.** Successful loan applicants under this section may receive loan disbursements as a lump sum or on an agreed upon disbursement schedule. The commissioner shall approve disbursements to successful loan applicants through a memorandum of understanding. Memoranda of understanding must specify the amount and schedule of loan disbursements.

Subd. 5. **Loan administration.** The commissioner may contract with an independent third party to administer the loan program under this section.

Subd. 6. **Loan payments.** The commissioner shall negotiate the terms of the loan repayment, including the start of the repayment plan, the due date of the repayment, and the frequency of the repayment installments. Repayment installments must not begin until at least 18 months after the first disbursement date. The memoranda of understanding must specify the amount and schedule of loan payments. The repayment term must not exceed 72 months. If any loan payment to the commissioner is not paid within the time specified by the memoranda of understanding, the late payment must be assessed a penalty rate of 0.01 percent of the original loan amount each month the payment is past due. ~~For nursing facilities, this late fee is not an allowable cost on the department's cost report.~~ The

commissioner shall have the power to abate penalties when discrepancies occur resulting from but not limited to circumstances of error and mail delivery.

Subd. 7. **Loan repayment.** (a) If a borrower is more than 60 calendar days delinquent in the timely payment of a contractual payment under this section, the provisions in paragraphs (b) to (e) apply.

(b) The commissioner may withhold some or all of the amount of the delinquent loan payment, together with any penalties due and owing on those amounts, from any money the department owes to the borrower. The commissioner may, at the commissioner's discretion, also withhold future contractual payments from any money the commissioner owes the provider as those contractual payments become due and owing. The commissioner may continue this withholding until the commissioner determines there is no longer any need to do so.

(c) The commissioner shall give prior notice of the commissioner's intention to withhold by mail, facsimile, or email at least ten business days before the date of the first payment period for which the withholding begins. The notice must be deemed received as of the date of mailing or receipt of the facsimile or electronic notice. The notice must state:

(1) ~~state~~ the amount of the delinquent contractual payment;

(2) ~~state~~ the amount of the withholding per payment period;

(3) ~~state~~ the date on which the withholding is to begin;

(4) ~~state~~ whether the commissioner intends to withhold future installments of the provider's contractual payments; and

(5) ~~state~~ other contents as the commissioner deems appropriate.

(d) The commissioner, or the commissioner's designee, may enter into written settlement agreements with a provider to resolve disputes and other matters involving unpaid loan contractual payments or future loan contractual payments.

(e) Notwithstanding any law to the contrary, all unpaid loans, plus any accrued penalties, are overpayments for the purposes of section 256B.0641, subdivision 1. The current ~~owner of a nursing home, boarding care home, or~~ long-term services and supports provider is liable for the overpayment amount owed by a former owner for any ~~facility~~ provider sold, transferred, or reorganized.

Subd. 7a. **Nursing home loans.** (a) All loans disbursed to nursing facilities under this section prior to August 1, 2025, must follow the criteria and repayment terms outlined in their executed loan agreements.

(b) In the event of a facility's closure prior to repayment, the commissioner must attempt to recover the unpaid amounts owed by the facility.

(c) By January 15 of each year, the commissioner must provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over nursing facilities of all facilities that are delinquent in their repayments.

Subd. 8. **Audit.** Loan money allocated under this section is subject to audit to determine whether the money was spent as authorized under this section.

Subd. 8a. **Special revenue account.** A long-term services and supports loan account is created in the special revenue fund in the state treasury. Money appropriated for the purposes of this section must be transferred to the long-term services and supports loan account. All payments received under subdivision 6, along with fees, penalties, and interest, must be deposited into the special revenue account and are appropriated to the commissioner for the purposes of this section.

Subd. 9. **Carryforward.** Notwithstanding section 16A.28, subdivision 3, money in the long-term services and supports loan account for the purposes under this section carries forward and does not lapse.

EFFECTIVE DATE. This section is effective for memoranda of understanding executed on or after August 1, 2025.

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

Subdivision 1. **Nursing home license surcharge.** (a) ~~Effective July 1, 1993,~~ Each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as ~~$620~~ $2,815 per licensed bed. If the number of licensed beds is ~~reduced~~ changed, 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~~ on the first day of the month following the change in number of licensed beds. The nursing home must notify the commissioner of health in writing when beds are licensed or 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~~ 90 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~~ January 1, 2026, or the first day of the month following federal approval, whichever is later, the surcharge under this subdivision shall be increased to $5,900.

~~(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.~~

~~(c)~~ (c) The commissioner ~~may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge~~ must decrease the amount under this subdivision as necessary to remain under the allowable federal tax percent in Code of Federal Regulations, title 42, part 433.

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

Sec. 6. 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~~ the board's intrastate funding formula.

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

Sec. 7. 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.

(c) State funds under this subdivision are subject to federal requirements in accordance with the Minnesota Board on Aging's intrastate funding formula.

Sec. 8. 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. Through December 31, 2026, 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. Beginning January 1, 2027, a facility is not allowed to change the facility's single bed election; 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. Beginning January 1, 2027, a facility is not allowed to change the facility's single bed election; 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 January 1, 2027.

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

Sec. 9. 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. 10. Minnesota Statutes 2024, section 256B.434, subdivision 4k, is amended to read:

Subd. 4k. **Property rate increase for certain nursing facilities.** (a) A rate increase under this subdivision ends upon the effective date of the transition of the facility's property rate to a property payment rate under section 256R.26, subdivision 8~~, or May 31, 2026, whichever is earlier~~.

(b) The commissioner shall increase the property rate of a nursing facility located in the city of St. Paul at 1415 Almond Avenue in Ramsey County by $10.65 on January 1, 2025.

(c) The commissioner shall increase the property rate of a nursing facility located in the city of Duluth at 3111 Church Place in St. Louis County by $20.81 on January 1, 2025.

(d) The commissioner shall increase the property rate of a nursing facility located in the city of Chatfield at 1102 Liberty Street SE in Fillmore County by $21.35 on January 1, 2025.

~~(e) Effective January 1, 2025, through June 30, 2025, the commissioner shall increase the property rate of a nursing facility located in the city of Fergus Falls at 1131 South Mabelle Avenue in Ottertail County by $38.56.~~

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

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

Subd. 14a. **CPI-U inflation.** "CPI-U inflation" means the percentage change in the Consumer Price Index-All Items (United States City average) (CPI-U) provided by the Reports and Forecasts Division of the Department of Human Services in the fourth quarter of the calendar year preceding the rate year based on the 12-month period ending with the midpoint of the reporting period for which CPI-U inflation is being applied to determine the rates and beginning with the midpoint of the previous reporting period.

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

Sec. 12. 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. 13. 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. 14. Minnesota Statutes 2024, section 256R.23, subdivision 7, is amended to read:

Subd. 7. **Determination of direct care payment rates.** A facility's direct care payment rate equals the lesser of (1) the facility's direct care costs per standardized day, ~~or~~ (2) the facility's direct care costs per standardized day divided by its cost to limit ratio, (3) the previous year's direct care payment rate times one plus CPI-U inflation, or (4) 104 percent of the previous year's direct care payment rate.

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

Sec. 15. Minnesota Statutes 2024, section 256R.23, subdivision 8, is amended to read:

Subd. 8. **Determination of other care-related payment rates.** A facility's other care-related payment rate equals the lesser of (1) the facility's other care-related cost per resident day, ~~or~~ (2) the facility's other care-related cost per resident day divided by its cost to limit ratio, (3) the previous year's other care-related rate times one plus CPI-U inflation, or (4) 104 percent of the previous year's other care-related payment rate.

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

Sec. 16. Minnesota Statutes 2024, section 256R.24, subdivision 3, is amended to read:

Subd. 3. **Determination of the other operating payment rate.** A facility's other operating payment rate equals the lesser of (1) 105 percent of the median other operating cost per day, (2) the previous year's other operating payment rate times one plus CPI-U inflation, or (3) 104 percent of the previous year's other operating payment rate.

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

Sec. 17. Minnesota Statutes 2024, section 256R.25, as amended by Laws 2025, chapter 38, article 1, section 27, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

Subd. 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 17.

Subd. 2. **Provider surcharges.** ~~(b)~~ (a) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to ~~$8.86~~ $19.02 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~~ $19.02 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The commissioner must decrease the portion related to the provider surcharge as necessary to conform to decreases in the nursing home license surcharge fee under section 256.9657.

(c) The commissioner must reduce the portion related to the provider surcharge on January 1 for each rate year the surcharge revenue received under section 256.9657, subdivision 1, in the previous state fiscal year is less than the forecasted amount by 15 percent or more. The commissioner's computation must be based on the forecast published most immediately prior to the beginning of the state fiscal year. A reduction of the portion related to the provider surcharge under this paragraph is equal to the difference between the forecasted amount and actual collections divided by total resident days from the most recent cost reports, not to exceed a ten dollar reduction per resident day.

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.

Subd. 6. **Planned closures.** ~~(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. 7. **Consolidations.** ~~(g)~~ The portion related to consolidation rate adjustments shall be as determined under section 256R.405.

Subd. 8. **Single-bed rooms.** ~~(h)~~ The portion related to single-bed room incentives is as determined under section 256R.41.

Subd. 9. **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. 10. **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. 11. **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. 12. **Quality improvement incentives.** ~~(l)~~ The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

Subd. 13. **Performance-based incentives.** ~~(m)~~ The portion related to performance-based incentive payments is the amount determined under section 256R.38.

Subd. 14. **Special diets.** ~~(n)~~ The portion related to special dietary needs is the amount determined under section 256R.51.

Subd. 15. **Border city facilities.** ~~(o)~~ The portion related to the rate adjustments for border city facilities is the amount determined under section 256R.481.

Subd. 16. **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. 17. **Nursing home employment standards.** The portion related to the rate adjustment for nursing home employment standards is the amount determined under section 256R.495.

EFFECTIVE DATE. The amendments to subdivisions 1 and 17 are effective January 1, 2026, or upon federal approval, whichever is later. The amendments to subdivision 2 are

effective January 1, 2026, or the first day of the month following 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 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 section 256R.40; consolidation rate adjustments under section ~~144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d~~ 256R.405; single-bed room incentives under 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. 19. 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 11;

(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. 20. 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 11;

(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. 21. Minnesota Statutes 2024, section 256R.41, is amended to read:

256R.41 SINGLE-BED ROOM INCENTIVE.

Subdivision 1. **Single-bed 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 through June 30, 2030. 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.

Subd. 2. **Single-bed incentive phase-out.** (a) Beginning January 1, 2027, the commissioner shall reduce the value of the single-bed incentive calculated under subdivision 1 as follows:

(1) January 1, 2027, through December 31, 2027, the single-bed incentive is 80 percent of the value calculated under subdivision 1;

(2) January 1, 2028, through December 31, 2028, the single-bed incentive is 60 percent of the value calculated under subdivision 1;

(3) January 1, 2029, through December 31, 2029, the single-bed incentive is 40 percent of the value calculated under subdivision 1;

(4) January 1, 2030, through December 31, 2030, the single-bed incentive is 20 percent of the value calculated under subdivision 1; and

(5) on or after January 1, 2031, the single-bed incentive is zero.

(b) The phase-out schedule in this subdivision applies to all existing and new rate adjustment amounts determined under subdivision 1.

Subd. 3. **Discharge prohibition.** ~~(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)~~ this section.

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

Sec. 22. 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. 23. **[256R.495] RATE ADJUSTMENT FOR NURSING HOME EMPLOYMENT STANDARDS.**

Subdivision 1. **Nursing home employment standards rate adjustment.** For each rate year for which section 181.213, subdivision 2b, is in effect, and for which the legislature appropriates money to fund a rate increase necessary to meet new employment standards established under section 181.213, a nursing facility's rate under this chapter must include a rate adjustment to pay for the nursing home employment standards promulgated by the Nursing Home Workforce Standards Board if the facility complies with the requirements in subdivision 2. To receive a rate adjustment under this section, a nursing facility must report to the commissioner the wage rate for every worker and contracted worker below a new minimum employment standard established by the board under section 181.213.

Subd. 2. **Application for rate adjustments.** To receive a rate adjustment under this section, a nursing facility must submit to the commissioner in a form and manner determined by the commissioner an application for each rate year in which a rate adjustment is available. The application must include data for a period beginning with the first pay period after June 1 of the year prior to the rate year in which the rate adjustment takes effect, including at least two months of worker-compensated hours by wage rate and a spending plan that describes how the money from the rate adjustment will be allocated for compensation to workers as defined by Minnesota Rules, part 5200.2060, who are paid less than the general wage standards defined in Minnesota Rules, part 5200.2080, and the wage standards for certain positions defined by Minnesota Rules, part 5200.2090. A nursing facility must submit the application by October 1 of the year prior to the rate year in which the rate adjustment takes effect. The commissioner may request any additional information needed to determine the rate adjustment. The nursing facility must provide any additional information requested by the commissioner within 20 calendar days of receiving a request from the commissioner for additional information. The commissioner may waive the deadlines in this subdivision under extraordinary circumstances.

Subd. 3. **Rate adjustment timeline.** Based on an approved application submitted under subdivision 2, the commissioner must calculate the amount of the rate adjustment based on the facility's approved application under subdivision 2 and include that amount in the facility's external fixed cost payment rate under section 256R.25. For each rate year for which a

nursing facility receives approval of the application under subdivision 2, the facility must receive a final rate adjustment according to the applicable subdivision of this section. The final rate adjustment must be included in the external fixed costs payment rate under section 256R.25 for two rate years.

Subd. 4. **January 1, 2026, rate adjustment calculation.** (a) For the rate year beginning January 1, 2026, the commissioner must calculate the annualized compensation costs by adding the totals of clauses (1) to (5). The result must be divided by the total resident days from the most recently available cost report to determine the preliminary rate adjustment for the nursing home employment standards:

(1) for certified nursing assistants, the sum of the difference between $22.50 and any hourly wage rate of less than $22.50 multiplied by the number of compensated hours at that wage rate;

(2) for trained medication aides, the sum of the difference between $23.50 and any hourly wage rate of less than $23.50 multiplied by the number of compensated hours at that wage rate;

(3) for licensed practical nurses, the sum of the difference between $27 and any hourly wage rate of less than $27 multiplied by the number of compensated hours at that wage rate;

(4) for all nursing home workers not included in clauses (1) to (3) who are subject to the minimum wage standards established by the board under section 181.213, the sum of the difference between $19 and any hourly wage rate less than $19 multiplied by the number of compensated hours at that wage rate; and

(5) the sum of the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts attributable to the amounts in clauses (1) to (4).

(b) If the aggregate net general fund spending under this subdivision does not exceed the increase in funding needed to increase payment rates to comply with the new employment standards as reported to the legislature by the Nursing Home Workforce Standards Board under section 181.213, the preliminary rate adjustment calculated under paragraph (a) is the final rate adjustment for the nursing home employment standards.

(c) If the aggregate net general fund spending under this subdivision exceeds the increase in funding needed to increase payment rates necessary to comply with the new employment standards as reported to the legislature by the Nursing Home Workforce Standards Board

under section 181.213, the commissioner must determine the final rate adjustment by reducing all preliminary rate adjustments calculated under paragraph (a) by an equal proportion such that the aggregate net general fund spending under this subdivision is equal to the amount reported to the legislature by the Nursing Home Workforce Standards Board.

Subd. 5. **January 1, 2027, rate adjustment calculation.** (a) For the rate year beginning January 1, 2027, the commissioner must calculate the annualized compensation costs by adding the totals of clauses (1) to (5). The result must be divided by the total resident days from the most recently available cost report to determine the final rate adjustment for the nursing home employment standards:

(1) for certified nursing assistants, the sum of the difference between $24 and any hourly wage rate of less than $24 multiplied by the number of compensated hours at that wage rate;

(2) for trained medication aides, the sum of the difference between $25 and any hourly wage rate of less than $25 multiplied by the number of compensated hours at that wage rate;

(3) for licensed practical nurses, the sum of the difference between $28.50 and any hourly wage rate of less than $28.50 multiplied by the number of compensated hours at that wage rate;

(4) for all nursing home workers not included in clauses (1) to (3) who are subject to the minimum wage standards established by the board under section 181.213, the sum of the difference between $20.50 and any hourly wage rate of less than $20.50 multiplied by the number of compensated hours at that wage rate; and

(5) the sum of the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts attributable to the amounts in clauses (1) to (4).

(b) If the aggregate net general fund spending under this subdivision does not exceed the increase in funding needed to increase payment rates necessary to comply with the new employment standards as reported to the legislature by the Nursing Home Workforce Standards Board under section 181.213, the preliminary rate adjustment calculated under paragraph (a) is the final rate adjustment for the nursing home employment standards.

(c) If the aggregate net general fund spending under this subdivision exceeds the increase in funding needed to increase payment rates necessary to comply with the new employment standards as reported to the legislature by the Nursing Home Workforce Standards Board

under section 181.213, the commissioner must determine the final rate adjustment by reducing all preliminary rate adjustments calculated under paragraph (a) by an equal proportion such that the aggregate net general fund spending under this subdivision is equal to the amount reported to the legislature by the Nursing Home Workforce Standards Board.

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. 24. **[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) October 1, 2025, through December 31, 2026, 75 percent;

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

(iii) January 1, 2028, 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) October 1, 2025, through December 31, 2026, 25 percent;

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

(iii) January 1, 2028, 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. 25. 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. 26. 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. 27. 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. 28. Minnesota Statutes 2024, section 256S.205, subdivision 7, is amended to read:

Subd. 7. **Expiration.** This section expires ~~January 1, 2026~~ May 31, 2028.

Sec. 29. Minnesota Statutes 2024, section 256S.205, is amended by adding a subdivision to read:

Subd. 8. **Coercion prohibited.** (a) A facility must not pressure, coerce, entice, or otherwise unduly influence a resident to become an elderly waiver participant. Every six months, each designated disproportionate share facility must submit a written attestation to the commissioner affirming that neither the facility nor any of its owners, operators, or employees pressured, coerced, enticed, or otherwise unduly influenced a resident to become an elderly waiver participant. If a facility fails to submit the required attestation to the commissioner within 60 days of the due date of the attestation, the commissioner must terminate the facility's designation. The facility may appeal the decision of the commissioner under section 256.045.

(b) The commissioner shall terminate a facility's designation as a disproportionate share facility upon a credible allegation of a facility violating this subdivision. The commissioner may also impose other sanctions under chapter 256B as the commissioner deems appropriate. The facility may appeal the decision of the commissioner under section 256.045.

Sec. 30. Minnesota Statutes 2024, section 256S.205, is amended by adding a subdivision to read:

Subd. 9. **Compensation requirements.** (a) A provider receiving a rate floor must use a minimum of 66 percent of the incremental increase in revenue generated by the rate floor under this section for direct care staff compensation.

(b) Compensation under this subdivision includes:

(1) wages;

(2) taxes and workers' compensation;

(3) health insurance;

(4) dental insurance;

(5) vision insurance;

(6) life insurance;

(7) short-term disability insurance;

(8) long-term disability insurance;

(9) retirement spending;

(10) tuition reimbursement;

(11) wellness programs;

(12) paid vacation time;

(13) paid sick time; or

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

Sec. 31. **LAWS EFFECTIVE DATE.**

Notwithstanding any other law to the contrary, Laws 2025, chapter 38, article 1, section 30, is effective January 1, 2026.

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

Sec. 32. **REPEALER.**

(a) Minnesota Statutes 2024, section 256R.02, subdivision 38, is 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.

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

ARTICLE 2
DISABILITY SERVICES

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

Subd. 12. **Minnesota Caregiver 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. 2. 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.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 3. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision to read:

Subd. 6. **Legal resources required.** If requested by a license holder that is (1) subject to an enforcement action under section 245A.06 or 245A.07, and (2) operating a program licensed under this chapter and chapter 245D, the commissioner must provide the license holder with a list of legal resources.

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

Sec. 4. 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, 2027, 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.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 5. 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.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 6. Minnesota Statutes 2024, section 245D.091, subdivision 2, as amended by Laws 2025, chapter 20, section 202, 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 148E, 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. 7. Minnesota Statutes 2024, section 245D.091, subdivision 3, as amended by Laws 2025, chapter 38, article 1, section 5, 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. 8. **[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 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 the setting's 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. 9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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.

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 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. 16. Minnesota Statutes 2024, section 256B.0911, subdivision 17, is amended to read:

Subd. 17. **MnCHOICES assessments.** (a) A ~~person requesting long-term care consultation services must be visited by a~~ long-term care consultation team must begin an assessment of a person requesting long-term care consultation services or for whom long-term care consultation services were recommended, including an estimated timeline to full completion of the assessment, within 20 working days after the date on which an assessment was requested or recommended.

(b) Assessments must be conducted according to this subdivision and subdivisions 19 to 21, 23, 24, and 29 to 31.

~~(b)~~ (c) Lead agencies shall use certified assessors to conduct the assessment.

~~(c)~~ (d) For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

~~(d)~~ (e) The lead agency must use the MnCHOICES assessment provided by the commissioner to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered assessment summary that meets the individual's needs and preferences.

~~(e)~~ (f) Except as provided in subdivision 24, an assessment must be conducted by a certified assessor in an in-person conversational interview with the person being assessed.

Sec. 17. 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. 18. Minnesota Statutes 2024, section 256B.0911, is amended by adding a subdivision to read:

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

(b) Within 30 days of completion of a reassessment, an assessor must send a request for written attestation via mail to obtain a signature from the service recipient.

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

Sec. 19. 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.

(f) The person has appeal rights under section 256.045, subdivision 3, if the assessor does not confirm that there are no changes in needs or 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. 20. Minnesota Statutes 2024, section 256B.0911, subdivision 30, is amended to read:

Subd. 30. **Assessment and support planning; supplemental information.** The lead agency must give the person receiving long-term care consultation services or the person's legal representative materials and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the person;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the person selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs and state plan home care, case management, and other services as defined in subdivision 11, clauses (7) to (10);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 26 and regarding eligibility for all services and programs as defined in subdivision 11, clauses (7) to (10);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 11, clauses (5), (7) to (10), and (15), and the decision regarding the need for institutional level of care, an attestation to no changes in needs or services, or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the person.

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

Subd. 34. **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 lead agency;

(5) the average length of time to complete an assessment, by 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.

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

Sec. 22. Minnesota Statutes 2024, section 256B.092, subdivision 1a, as amended by Laws 2025, chapter 38, article 1, section 16, is amended to read:

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

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

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

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

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

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

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

(ii) employment service providers;

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

(iv) providers of financial management services;

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

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

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

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

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. If a county agency contracts for case management services, the county agency must provide each recipient of home and community-based services who is receiving contracted case management services with the contact information the recipient may use to file a grievance with the county agency about the quality of the contracted services the recipient is receiving from a county-contracted case manager. 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 appropriate service authorization, person-centered planning, informed choice, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete

an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. 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. 23. Minnesota Statutes 2024, section 256B.092, subdivision 3, is amended to read:

Subd. 3. **Authorization and termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to support plans. Except as provided in subdivision 3b, services provided to persons with developmental disabilities may only be authorized and terminated by case managers or certified assessors according to (1) rules of the commissioner and (2) the support plan as defined in subdivision 1b. Medical assistance services not needed shall not be authorized by county agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

Sec. 24. Minnesota Statutes 2024, section 256B.092, is amended by adding a subdivision to read:

Subd. 3b. **Service authorizations and service agreements.** (a) Recipients must be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

(b) 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.

(c) For a service agreement 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.

(d) 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 (c):

(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 that require 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.

(e) 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 (c) 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.

(f) This subdivision expires upon full implementation of waiver reimagine. The commissioner must inform the revisor of statutes when waiver reimagine is fully implemented.

Sec. 25. 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. 26. Minnesota Statutes 2024, section 256B.49, subdivision 13, as amended by Laws 2025, chapter 38, article 1, section 18, 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, person-centered planning, informed choice, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. 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. 27. Minnesota Statutes 2024, section 256B.49, is amended by adding a subdivision to read:

Subd. 17a. **Service authorizations and service agreements.** (a) Recipients must be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

(b) 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.

(c) For a service agreement 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.

(d) 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 (c):

(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 that require 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.

(e) 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 (c) 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.

(f) This subdivision expires upon full implementation of waiver reimagine. The commissioner must inform the revisor of statutes when waiver reimagine is fully implemented.

Sec. 28. 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. 29. **[256B.4907] ADVISORY TASK FORCE ON WAIVER REIMAGINE.**

Subdivision 1. **Membership; co-chairs.** (a) The Advisory Task Force on Waiver Reimagine consists of the following members:

(1) one member of the house of representatives, appointed by the speaker of the house;

(2) one member of the house of representatives, appointed by the leader of the house of representatives Democratic-Farmer-Labor caucus;

(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) four individuals currently receiving disability waiver services who are under the age of 65, appointed by the governor;

(6) one county employee who conducts long-term care consultation services assessments for persons under the age of 65, appointed by the Minnesota Association of County Social Services Administrators;

(7) one representative of the Department of Human Services with knowledge of the requirements for a provider to participate in disability waiver service programs and of the administration of benefits, appointed by the commissioner of human services;

(8) one employee of the Minnesota Council on Disability, appointed by the Minnesota Council on Disability;

(9) two representatives of disability advocacy organizations, appointed by the governor;

(10) two family members of individuals who are receiving disability waiver services, appointed by the governor;

(11) two providers of disability waiver services for persons who are under the age of 65, appointed by the governor;

(12) one employee from the Office of Ombudsman for Mental Health and Developmental Disabilities, appointed by the ombudsman;

(13) one employee from the Olmstead Implementation Office, appointed by the director of the office;

(14) the assistant commissioner of the Department of Human Services administration that oversees disability services; and

(15) a member of the Minnesota Disability Law Center, appointed by the executive director of Mid-Minnesota Legal Aid.

(b) Each appointing authority must make appointments by September 30, 2025. Appointments made by an agency or commissioner may also be made by a designee.

(c) In making task force appointments, the governor must ensure representation from greater Minnesota.

(d) The Office of Collaboration and Dispute Resolution must convene the task force.

(e) The task force members must elect co-chairs from the membership of the task force at the first task force meeting.

Subd. 2. **Meetings; administrative support.** (a) The first meeting of the task force must be convened no later than November 30, 2025. The task force must meet at least quarterly. Meetings are subject to chapter 13D. The task force may meet by telephone or interactive technology consistent with section 13D.015.

(b) The Department of Human Services shall provide meeting space and administrative and research support to the task force.

Subd. 3. **Duties.** (a) The task force must make findings and recommendations related to Waiver Reimagine in Minnesota, including but not limited to the following:

(1) consolidation of the existing four disability home and community-based waiver service programs into two waiver programs;

(2) budgets based on the needs of the individual that are not tied to location of services, including resources beyond those required to meet assessed needs that may be necessary for the individual to live in the least restrictive environment;

(3) criteria and processes for provider rate exceptions and individualized budget exceptions;

(4) appropriate assessments, including the MnCHOICES 2.0 assessment tool, in determining service needs and individualized budgets;

(5) covered services under each disability waiver program, including any proposed adjustments to the menu of services;

(6) service planning and authorization processes for disability waiver services;

(7) a plan of support, financial and otherwise, to live in the person's own home and in the most integrated setting as defined under Title 2 of the Americans with Disabilities Act Integration Mandate and in Minnesota's Olmstead Plan;

(8) intended and unintended outcomes of Waiver Reimagine; and

(9) other items related to Waiver Reimagine as necessary.

(b) The task force must seek input from the public, counties, persons receiving disability waiver services, families of persons receiving disability waiver services, providers, state agencies, and advocacy groups.

(c) The task force must hold public meetings to gather information to fulfill the purpose of the task force. The meetings must be accessible by remote participants.

(d) The Department of Human Services shall provide relevant data and research to the task force to facilitate the task force's work.

Subd. 4. **Compensation; expenses.** Members of the task force may receive compensation and expense reimbursement as provided in section 15.059, subdivision 3.

Subd. 5. **Report.** (a) The task force shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over disability waiver services no later than January 15, 2027, that describes any concerns or recommendations related to Waiver Reimagine as identified by the task force.

(b) The report required under Laws 2021, First Special Session chapter 7, article 13, section 75, subdivision 4, as amended by Laws 2024, chapter 108, article 1, section 28, must be presented to the task force prior to December 15, 2026.

Subd. 6. **Task force does not expire.** Notwithstanding section 15.059, subdivision 6, the task force under this section does not expire.

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

Sec. 30. 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. 31. 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~~ establish the base wage index in subdivision 5a, publish these updated values, and load them into the rate management system ~~as follows:~~

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

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

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

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

Sec. 32. Minnesota Statutes 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. 33. Minnesota Statutes 2024, section 256B.4914, subdivision 5b, is amended to read:

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

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

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

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

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

Sec. 34. Minnesota Statutes 2024, section 256B.4914, subdivision 8, is amended to read:

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

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

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 15.5 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

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

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

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

(e) Effective January 1, 2026, or upon federal approval, whichever is later, a provider must not bill more than three consecutive hours and not more than six total hours per day for individualized home supports with training and individualized home supports with family training. This daily limit does not limit a person's use of other disability waiver services, including individualized home supports, which may be provided on the same day by the same provider providing individualized home supports with training or individualized home supports with family training.

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

Sec. 35. Minnesota Statutes 2024, section 256B.4914, subdivision 9, is amended to read:

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

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

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

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

Sec. 36. 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 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 lead agency must include:

(1) a documented behavioral diagnosis; or

(2) determined assessed needs for behavioral supports as identified in the person's most recent assessment or reassessment under section 256B.0911.

(d) Community residential services rate exceptions must not include positive support services 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 documentation supporting the continuation of the exception. At a minimum, documentation must include:

(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. 37. 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. 38. 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. 39. 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. 40. 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. 41. 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. 42. Minnesota Statutes 2024, section 256B.85, subdivision 7a, is amended to read:

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

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e).

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

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

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

Sec. 43. 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. 44. 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. 45. 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. 46. 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. 47. 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 upon the effective date of paragraph (f).

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

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

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

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

Sec. 48. 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. 49. 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. 50. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5a. **Payment rates; implementation components.** 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.

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

Sec. 51. 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.

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

Sec. 52. 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.

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

Sec. 53. 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. 54. 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.

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. 55. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 7a. **Budget determinations.** Effective January 1, 2026, 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. Effective January 1, 2027, the commissioner must 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 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.

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. 56. 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.

~~(e)~~ (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.

(g) No later than July 1, 2026, the commissioner must:

(1) develop and implement an online support planning and tracking tool to provide information in an accessible format to support informed choice for people using disability waiver services that allows access to the total budget available to a person, the services for which they are eligible, and the services they have chosen and used;

(2) explore operability options that facilitate real-time tracking of a person's remaining available budget throughout the service year; and

(3) seek input from people with disabilities about the online support planning and tracking tool prior to the tool's implementation.

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

Sec. 57. 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. 58. **LONG-TERM SERVICES AND SUPPORTS ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** The commissioner of human services shall convene a long-term services and supports advisory council to advise and assist the legislature and the governor to reduce cost growth in long-term services and supports, build greater efficiencies into the long-term care services system, and achieve better outcomes for Minnesotans with long-term care needs.

Subd. 2. **Membership; appointment.** (a) The advisory council consists of at least 30 members as follows:

(1) the commissioner of human services or a designee;

(2) the chief executive officer of direct care and treatment or a designee;

(3) one individual receiving services under the elderly waiver, appointed by Elder Voices Family Advocates;

(4) two people with disabilities, one living in a community residential setting and one living independently, appointed by the ARC Minnesota;

(5) three family members of people with disabilities or older adults utilizing medical assistance services, one of whom has professional experience with disability waiver services, one of whom who has had experience in advocacy, and one of whom is a parent of a child with autism, all appointed by the commissioner of human services from among the membership of the Waiver Reimagine Advisory Committee;

(6) two county representatives, one of whom must be from greater Minnesota and one of whom must be from the Twin Cities metropolitan area, both appointed by the Association of Minnesota Counties;

(7) two county representatives, one of whom must be from greater Minnesota and one of whom must be from the Twin Cities metropolitan area, both appointed by the Minnesota Inter-County Association;

(8) two county social services workers, one of whom must be from greater Minnesota and one of whom must be from the Twin Cities metropolitan area, both appointed by the Minnesota Association of County Social Service Administrators;

(9) two representatives from Tribal Nations involved in the administration of social services, appointed by the Minnesota Indian Affairs Council;

(10) one provider of home care services, appointed by the Minnesota Home Care Association;

(11) one provider of nursing facility services to older adults and people with disabilities, appointed by the Long-Term Care Imperative;

(12) three providers of home and community-based disability services, one appointed by MOHR, one appointed by Residential Providers Association of Minnesota, and one appointed by ARRM. The appointing authorities under this clause must coordinate to ensure that one day services provider, one community residential services provider, and one own-home service provider is appointed;

(13) two advocates for people with disabilities, one appointed by the Disability Law Center and one appointed by the ARC Minnesota;

(14) one advocate for older adults utilizing long-term care services, appointed by the ombudsman for long-term care;

(15) one advocate for people with mental illness or developmental disabilities utilizing long-term services and supports, appointed by the ombudsman for mental health and developmental disabilities;

(16) one provider of long-term services and supports, appointed by Community Provider Alliance;

(17) one provider of community first services and supports, appointed by Minnesota First Provider Alliance;

(18) one member, appointed by the Service Employees International Union (SEIU) Healthcare Minnesota & Iowa;

(19) one member appointed by the American Federation of State, County, & Municipal Employees (AFSCME);

(20) one individual living with serious and persistent mental illness, appointed by National Alliance on Mental Illness (NAMI) Minnesota; and

(21) any other individuals the commissioner of human services chooses to appoint.

(b) Each appointing authority must make appointments by September 1, 2025. Appointments made by an agency or commissioner may also be made by a designee.

(c) An appointing authority may designate an alternate member to attend and participate in advisory council meetings in the appointed member's stead, including replacing an appointed member at the appointing authority's discretion.

(d) An appointing authority may replace any member who steps down from the advisory council and replace any member who it appointed and who, in the judgment of the appointing authority, fails to attend a sufficient number of advisory council meetings.

Subd. 3. **Chair.** The commissioner of human services or the commissioner's designee shall serve as chair of the advisory council. The commissioner of human services must convene the first meeting no later than October 1, 2025.

Subd. 4. **Compensation; expenses; reimbursement.** Public members shall be compensated and reimbursed for expenses as provided in Minnesota Statutes, section 15.0575, subdivision 3.

Subd. 5. **Administrative support.** (a) The commissioner of human services shall provide meeting space and administrative support to the advisory council, including facilitating public testimony before the advisory council and coordinating other forms of public engagement with the advisory council.

(b) The commissioner of human services must contract with a third party to provide facilitation services for the advisory council. 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.

(d) The commissioner of human services shall compile and provide summary data and existing information the advisory council requests in a manner consistent with Minnesota Statutes, chapter 13.

Subd. 6. **Meetings.** (a) The advisory council must meet at least once every two months until the advisory council submits recommendations to the legislature required under subdivision 7. The advisory council must provide opportunities for public input, including oral public testimony.

(b) The advisory council may form work groups as deemed necessary by the advisory council.

Subd. 7. **Duties.** (a) By March 15, 2026, the commissioner or designee must present a progress update on the advisory council's work including any initial recommendations to the legislative committees with jurisdiction over human services.

(b) By December 1, 2026, the advisory council must submit to the legislature and the governor recommendations to reduce cost growth in long-term services and supports, to build greater efficiencies into the long-term care services system, and to promote better outcomes for Minnesotans with long-term care needs. When developing the recommendations, the advisory council must consider at least the following:

(1) approaches to reducing human services expenditures, including identifying strategies for addressing the significant cost drivers of state spending on long-term services and supports;

(2) cost-saving reforms, including reforms to:

(i) licensing requirements, service standards, provider qualifications, and provider duties and responsibilities;

(ii) eligibility requirements for accessing long-term care;

(iii) covered services, service authorizations, service limits, and budget limits;

(iv) rate methodologies, rate enhancements and add-ons, rate exceptions, and rate limits; or

(v) any other cost-saving reforms to medical assistance long-term services and supports and other programs serving Minnesotans with long-term care needs;

(3) alternative service models to provide long-term services and supports to people with limited dependencies, low-acuity assessed needs, or natural supports that may include: 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 for the target population similar 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 long-term needs 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;

(4) strategies to increase administrative efficiencies and improve program simplification within publicly funded long-term services and supports programs, including examining the roles and experience of counties and Tribes in delivering services and identifying any

conflicting and duplicative roles and responsibilities among the Department of Human Services, counties, Tribes, and other lead agencies; and

(5) opportunities for reducing fraud and improving program integrity in long-term services and supports.

(c) The commissioner must continue to collaborate with the advisory council after the December 1, 2026, recommendations are submitted under paragraph (b) until the advisory council expires under subdivision 11.

(d) The commissioner of human services may contract with a private entity or consultant as necessary to complete the duties under this section. Use of a private entity or consultant for this purpose is exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

(e) For all strategies included in the recommendations, the advisory council must include:

(1) the estimated fiscal impact of the strategy;

(2) the anticipated impact to people receiving services; and

(3) the level of support among members of the advisory council or ranking of each strategy determined by the advisory council.

Subd. 8. **Limitations.** In developing the recommendations, the advisory council shall take into consideration the impact of its recommendations on:

(1) the existing capacity of state agencies, including staffing needs, technology resources, and existing agency responsibilities; and

(2) the capacity of county and Tribal partners.

Subd. 9. **Savings determinations.** (a) When preparing the forecast for state revenue and expenditures under Minnesota Statutes, section 16A.103, the commissioner of management and budget must assume the following reductions of human services general fund spending for the biennium beginning July 1, 2027, until the end of the legislative session that enacts a budget for the commissioner of human services for the biennium beginning July 1, 2027:

(1) if a bond appropriation for the replacement of the Miller Building on the Anoka Metro Regional Treatment Center Campus is enacted during a 2025 special session, $177,542,000; or

(2) if a bond appropriation for the replacement of the Miller Building on the Anoka Metro Regional Treatment Center Campus is not enacted during a 2025 special session, $143,542,000.

(b) Upon enactment of a budget for the commissioner of human services for the biennium beginning July 1, 2027, the legislature must identify enacted provisions that were recommended by the advisory council under subdivision 7.

(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 spending reductions described in subdivision 10, beginning July 1, 2027, or upon federal approval, whichever is later.

Subd. 10. **Contingent spending reductions.** If upon enactment of a budget for the commissioner 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 9, paragraph (b), are less than the assumed savings in subdivision 9, paragraph (a), beginning July 1, 2027, or upon federal approval, whichever is later, the commissioner of human services must implement the following changes to produce an amount of savings in the biennium beginning July 1, 2027, equal to the difference between savings attributable to the enacted provisions identified under subdivision 9, paragraph (b), and the applicable assumed savings in subdivision 9, paragraph (a):

(1) if a bond appropriation for the replacement of the Miller Building on the Anoka Metro Regional Treatment Center Campus is enacted during a 2025 special session:

(i) adjust the value of the competitive workforce factors in Minnesota Statutes, section 256B.4914, subdivisions 6 to 9, to produce 49.58 percent of the required savings; and

(ii) impose a county share of medical assistance costs not paid by federal funds for services provided to a person receiving community residential services, family residential services, customized living services, or integrated community supports reimbursed under Minnesota Statutes, section 256B.4914, to produce 50.42 percent of the required savings; or

(2) if a bond appropriation for the replacement of the Miller Building on the Anoka Metro Regional Treatment Center Campus is not enacted during a 2025 special session:

(i) adjust the value of the competitive workforce factors in Minnesota Statutes, section 256B.4914, subdivisions 6 to 9, to produce 49.48 percent of the required savings; and

(ii) impose a county share of medical assistance costs not paid by federal funds for services provided to a person receiving community residential services, family residential

services, customized living services, or integrated community supports reimbursed under Minnesota Statutes, section 256B.4914, to produce 50.52 percent of the required savings.

Subd. 11. **Expiration.** The advisory council expires July 1, 2028.

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

Sec. 59. **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 positive support specialist, positive support analyst, and positive support professional level;

(2) create tools providers may use to track whether the provider's positive support 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 the provider's 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 via preexisting 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. 60. **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. 61. **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 enhancement 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. 62. **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. 63. **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. 64. **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 spending 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 general fund spending of $18,000,000 for the biennium beginning July 1, 2027, until the end of the legislative session that enacts a budget for the commissioner of human services for the biennium beginning July 1, 2027.

(b) Upon enactment of a budget for the commissioner 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 3.

Subd. 3. **Contingent reimbursement reductions.** If upon enactment of a budget for the commissioner 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 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. 65. **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. 66. **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. 67. **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. 68. **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 25.84 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. 69. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; OPTIONAL CONSULTATION SERVICES.**

The commissioner of human services may submit 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. 70. **REPEALER.**

Subdivision 1. **Direct care provider premiums.** Laws 2023, chapter 59, article 3, section 11, is repealed.

Subd. 2. **Legislative Task Force on Guardianship.** Laws 2024, chapter 127, article 46, section 39, is repealed.

Subd. 3. **Repealing laws.** (a) Laws 2021, First Special Session chapter 7, article 13, section 75, subdivision 3, as amended by Laws 2024, chapter 108, article 1, section 28, is repealed.

(b) 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 repealed.

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

ARTICLE 3
HEALTH CARE

Section 1. 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.

(d) For applicants subject to expedited review, medical assistance providers must comply with subdivision 29. If electronic health records are unavailable, requesting providers must coordinate with the state medical review team to obtain the medical records necessary to support the disability determination.

(e) The commissioner must maintain a contract for electronic signature and document transmission services to support expedited determinations.

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

Sec. 2. 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.

ARTICLE 4
SUBSTANCE USE DISORDER TREATMENT

Section 1. Minnesota Statutes 2024, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish state certification and recertification processes for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification or recertification process and requirements. Any changes to the certification or recertification process or requirements must be consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration. The commissioner must allow a transition period for CCBHCs to meet the revised criteria on or before January 1, 2025. The commissioner is authorized to amend the state's Medicaid state plan or the terms of the demonstration to comply with federal requirements.

(b) As part of the state CCBHC certification and recertification processes, the commissioner shall provide to entities applying for certification or requesting recertification the standard requirements of the community needs assessment and the staffing plan that are consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(c) The commissioner shall schedule a certification review that includes a site visit within 90 calendar days of receipt of an application for certification or recertification.

(d) Entities that choose to be CCBHCs must:

(1) complete a community needs assessment and complete a staffing plan that is responsive to the needs identified in the community needs assessment and update both the community needs assessment and the staffing plan no less frequently than every 36 months;

(2) comply with state licensing requirements and other requirements issued by the commissioner;

(3) employ or contract with a medical director. A medical director must be a physician licensed under chapter 147 and either certified by the American Board of Psychiatry and Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible for board certification in psychiatry. A registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization may serve as the medical director when a CCBHC is unable to employ or contract a qualified physician;

(4) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(5) ensure that clinic services are available and accessible to individuals and families of all ages and genders with access on evenings and weekends and that crisis management services are available 24 hours per day;

(6) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(7) comply with quality assurance reporting requirements and other reporting requirements included in the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration;

(8) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services through existing mobile crisis services; screening, assessment, and diagnosis services, including risk

assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to subdivision 3a;

(9) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs;

(10) be certified as a mental health clinic under section 245I.20;

(11) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations that are consistent with this section;

(12) be licensed to provide substance use disorder treatment under chapter 245G;

(13) be certified to provide children's therapeutic services and supports under section 256B.0943;

(14) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(15) be enrolled to provide mental health crisis response services under section 256B.0624;

(16) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(17) provide services that comply with the evidence-based practices described in subdivision 3d;

(18) provide peer services as defined in sections 256B.0615, 256B.0616, and 245G.07, subdivision ~~2~~ 2a, paragraph (b), clause ~~(8)~~ (2), as applicable when peer services are provided; and

(19) inform all clients upon initiation of care of the full array of services available under the CCBHC model.

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 245.91, subdivision 4, as amended by Laws 2025, chapter 38, article 8, section 48, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency, facility, or program that provides services or treatment for mental illness, developmental disability, or substance use disorder that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; a ~~sober home~~ recovery residence as defined in section 254B.01, subdivision 11; peer recovery support services provided by a recovery community organization as defined in section 254B.01, subdivision 8; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, or substance use disorder.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 3. Minnesota Statutes 2024, section 245F.08, subdivision 3, is amended to read:

Subd. 3. **Peer recovery support services.** Peer recovery support services must meet the requirements in section 245G.07, subdivision ~~2~~ 2a, paragraph (b), clause ~~(8)~~ (2), and must be provided by a person who is qualified according to the requirements in section 245F.15, subdivision 7.

EFFECTIVE DATE. This section is effective 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, 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.

Sec. 5. 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. 6. 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. 7. 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. 8. 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. 9. 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. 10. 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, 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, 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. 12. 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. 13. 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. 14. 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. 15. 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. 16. 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. 17. 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.

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.11, is amended by adding a subdivision to read:

Subd. 12. **Behavioral health practitioners.** (a) A behavioral health practitioner must meet the qualifications in section 245I.04, subdivision 4.

(b) A behavioral health practitioner working within a substance use disorder treatment program licensed under this chapter has the following scope of practice:

(1) a behavioral health practitioner may provide clients with recovery support services, as defined in section 245G.07, subdivision 2a, paragraph (b), clause (1); and

(2) a behavioral health practitioner must not provide treatment supervision to other staff persons.

(c) A behavioral health practitioner working within a substance use disorder treatment program licensed under this chapter must receive at least one hour of supervision per month on individual service delivery from an alcohol and drug counselor or a mental health professional who has substance use treatment and assessments within the scope of their practice.

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 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. 20. Minnesota Statutes 2024, section 245G.22, subdivision 15, as amended by Laws 2025, chapter 38, article 5, section 26, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must offer at least ~~50 consecutive minutes~~ four 15-minute 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~~ four 15-minute units 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) The ten-week time frame may include a client's previous time at another opioid treatment program licensed in Minnesota under this section if:

(1) the client was enrolled in the other opioid treatment program immediately prior to admission to the license holder's program;

(2) the client did not miss taking a daily dose of medication to treat an opioid use disorder; and

(3) the license holder obtains from the previous opioid treatment program the client's number of days in comprehensive maintenance treatment, discharge summary, amount of

daily milligram dose of medication for opioid use disorder, and previous three drug abuse test results.

(c) 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. 21. Minnesota Statutes 2024, section 254A.19, subdivision 4, is amended to read:

Subd. 4. **Civil commitments.** For the purposes of determining level of care, a comprehensive assessment does not need to be completed for an individual being committed as a chemically dependent person, as defined in section 253B.02, and for the duration of a civil commitment under section 253B.09 or 253B.095 in order for ~~a county~~ the individual to ~~access~~ be eligible for the behavioral health fund under section 254B.04. The ~~county~~ commissioner must determine if the individual meets the financial eligibility requirements for the behavioral health fund under section 254B.04.

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

Sec. 22. 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. 23. Minnesota Statutes 2024, section 254B.01, subdivision 11, is amended to read:

Subd. 11. **~~Sober home~~ Recovery residence.** A ~~sober home~~ recovery residence is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that:

(1) provides temporary housing to persons with substance use disorders;

(2) stipulates that residents must abstain from using alcohol or other illicit drugs or substances not prescribed by a physician;

(3) charges a fee for living there;

(4) does not provide counseling or treatment services to residents;

(5) promotes sustained recovery from substance use disorders; and

(6) follows the sober living guidelines published by the federal Substance Abuse and Mental Health Services Administration.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 24. Minnesota Statutes 2024, section 254B.02, subdivision 5, is amended to read:

Subd. 5. ~~**Local agency**~~ **Tribal allocation.** The commissioner may make payments to ~~local agencies~~ Tribal Nation servicing agencies from money allocated under this section to support individuals with substance use disorders and determine eligibility for behavioral health fund payments. The payment must not be less than 133 percent of the ~~local agency~~ Tribal Nations payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

Sec. 25. Minnesota Statutes 2024, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. ~~**Local agency duties**~~ **Financial eligibility determinations.** (a) ~~Every local agency~~ The commissioner of human services or Tribal Nation servicing agencies must determine financial eligibility for substance use disorder services and provide substance use disorder services to persons residing within its jurisdiction who meet criteria established by the commissioner. Substance use disorder money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the commissioner of human services shall select eligible vendors of substance use disorder services who can provide economical and appropriate treatment. ~~Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05.~~ The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that

necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate.

(c) An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

~~(d) Beginning July 1, 2022, local agencies shall not make placement location determinations.~~

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

Sec. 26. Minnesota Statutes 2024, section 254B.03, subdivision 3, is amended to read:

Subd. 3. **~~Local agencies~~ Counties to pay state for county share.** ~~Local agencies~~ Counties shall pay the state for the county share of the services authorized by the ~~local agency~~ commissioner, except when the payment is made according to section 254B.09, subdivision 8.

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

Sec. 27. Minnesota Statutes 2024, section 254B.04, subdivision 1a, as amended by Laws 2025, chapter 38, article 7, section 4, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the ~~local agency~~ commissioner to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (9).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 142G;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to ~~9505.0150~~ 9505.0140;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to ~~9500.1318~~ 9500.1272; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by ~~a local agency~~ the commissioner under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund,

the county is responsible for the payment to the regional treatment center according to section 254B.05, subdivision 4.

(i) Persons enrolled in MinnesotaCare are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section 256B.0632.

(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. Paragraph (d) is effective July 1, 2025. Paragraphs (b), (g), and (j) are effective July 1, 2026.

Sec. 28. Minnesota Statutes 2024, section 254B.04, subdivision 5, is amended to read:

Subd. 5. ~~**Local agency**~~ **Commissioner responsibility to provide administrative services.** The ~~local agency~~ commissioner of human services may employ individuals to conduct administrative activities and facilitate access to substance use disorder treatment services.

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

Sec. 29. Minnesota Statutes 2024, section 254B.04, subdivision 6, is amended to read:

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

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

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

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

(i) the client;

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

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

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

(i) the client;

(ii) the client's spouse;

(iii) the client's minor children; and

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

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

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

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

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

~~(g)~~ (f) The ~~local agency~~ commissioner must ~~redetermine~~ determine a client's eligibility for the behavioral health fund ~~every 12 months~~ for a 60-consecutive-calendar-day period per calendar year.

~~(h)~~ (g) A client, responsible relative, and policyholder must provide income or wage verification, household size verification, and must make an assignment of third-party payment rights under paragraph ~~(f)~~ (e). If a client, responsible relative, or policyholder does not comply with the provisions of this subdivision, the client is ineligible for behavioral health

fund payment for substance use disorder treatment, and the client and responsible relative must be obligated to pay for the full cost of substance use disorder treatment services provided to the client.

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

Sec. 30. Minnesota Statutes 2024, section 254B.04, subdivision 6a, is amended to read:

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

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

Sec. 31. Minnesota Statutes 2024, section 254B.05, subdivision 1, as amended by Laws 2025, chapter 38, article 4, section 31, 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 (15), complies with the training requirements in section 254B.052, subdivision 4, and meets certification requirements of the Minnesota Alliance of Recovery Community Organizations or another Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. If the commissioner does not identify another statewide recovery organization, or the Minnesota Alliance of Recovery Community Organizations or the statewide recovery organization identified by the commissioner is not reasonably positioned to certify vendors, the commissioner must determine the eligibility of a vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification 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;

(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; and

(15) comply with the requirements of section 245A.04, subdivision 15a.

(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 a certification 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 for up to two years from the date of the determination. After two years, the recovery community organization must apply for certification under paragraph (d) to continue to be an eligible vendor of peer recovery support services.

(g) All recovery community organizations must be certified by an entity listed in paragraph (d) by June 30, 2027.

(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. 32. Minnesota Statutes 2024, section 254B.05, subdivision 1a, as amended by Laws 2025, chapter 38, article 7, section 5, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site whenever a client is present;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(d) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

(e) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0624 or 256B.0632 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

(f) A vendor that is not licensed as a residential treatment program must have a policy to address staffing coverage when a client may unexpectedly need to be present at the room and board site.

(g) No new vendors for room and board services may be approved after June 30, 2025, to receive payments from the behavioral health fund, under the provisions of section 254B.04, subdivision 2a. Room and board vendors that were approved and operating prior to July 1, 2025, may continue to receive payments from the behavioral health fund for services provided until June 30, 2027. Room and board vendors providing services in accordance with section 254B.04, subdivision 2a, will no longer be eligible to claim reimbursement for room and board services provided on or after July 1, 2027.

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

Sec. 33. Minnesota Statutes 2024, section 254B.05, subdivision 5, as amended by Laws 2025, chapter 38, article 4, section 32, 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~~ 2a, paragraph (b), clause ~~(8)~~ (2);

(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, excluding weekends and holidays;

(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 July 1, 2025, except for the change to the new paragraph (a), clause (4), which is effective July 1, 2026, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 34. Minnesota Statutes 2024, section 254B.05, is amended by adding a subdivision to read:

Subd. 6. **Rate adjustments.** (a) Effective for services provided 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 services, 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, 83 percent of the modeled rate included in the final report required by Laws 2021, First Special Session chapter 7, article 17, section 18; and

(3) for treatment coordination services, 100 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, 2027, 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.

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

Sec. 35. Minnesota Statutes 2024, section 254B.052, is amended by adding a subdivision to read:

Subd. 4. **Recovery community organization vendor compliance training.** (a) Effective January 1, 2027, in order to enroll as an eligible vendor of peer recovery support services, a recovery community organization must require all owners active in day-to-day management and operations of the organization and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner, and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) eligible vendor enrollment requirements;

(3) provider program integrity, including fraud prevention, fraud detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) Any new owners active in day-to-day management and operations of the organization and managerial and supervisory employees must complete the training under this subdivision in order to be employed by or conduct management and operations activities for the organization. If the individual moves to another recovery community organization and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) By July 1, 2026, the commissioner must make the training required under this subdivision available in person, online, or by electronic remote connection.

(d) A recovery community organization enrolled as an eligible vendor before January 1, 2027, must document completion of the compliance training as required under this subdivision by January 1, 2028, and every three years thereafter.

Sec. 36. 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. 37. 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. 38. **[254B.21] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of sections 254B.21 to 254B.216, the following terms have the meanings given.

Subd. 2. **Applicant.** "Applicant" means any individual, organization, or entity who has applied for certification of a recovery residence.

Subd. 3. **Certified recovery residence.** "Certified recovery residence" means a recovery residence that has completed the application process and been approved for certification by the commissioner.

Subd. 4. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both a substance use disorder and a mental health disorder.

Subd. 5. **Operator.** "Operator" means the lawful owner or lessee of a recovery residence or a person employed and designated by the owner or lessee of the recovery residence to

have primary responsibility for oversight of the recovery residence, including but not limited to hiring and termination of recovery residence staff, recovery residence maintenance, and responding to complaints being investigated by the commissioner.

Subd. 6. **Recovery residence.** "Recovery residence" means a type of community residence that provides a safe, healthy, family-like, substance-free living environment that supports individuals in recovery from substance use disorder.

Subd. 7. **Recovery residence registry.** "Recovery residence registry" means the list of certified recovery residences maintained by the commissioner.

Subd. 8. **Resident.** "Resident" means an individual who resides in a recovery residence.

Subd. 9. **Staff.** "Staff" means employees, contractors, or volunteers who provide monitoring, assistance, or other services for the use and benefit of a recovery residence and the residence's residents.

Subd. 10. **Substance free.** "Substance free" means being free from the use of alcohol, illicit drugs, and the illicit use of prescribed drugs. This term does not prohibit medications prescribed, dispensed, or administered by a licensed health care professional, such as pharmacotherapies specifically approved by the United States Food and Drug Administration (FDA) for treatment of a substance use disorder as well as other medications approved by the FDA for the treatment of co-occurring disorders when taken as directed.

Subd. 11. **Substance use disorder.** "Substance use disorder" has the meaning given in the most recent edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 39. **[254B.211] RESIDENCE REQUIREMENTS AND RESIDENT RIGHTS.**

Subdivision 1. **Applicability.** This section is applicable to all recovery residences regardless of certification status.

Subd. 2. **Residence requirements.** All recovery residences must:

(1) comply with applicable state laws and regulations and local ordinances related to maximum occupancy, fire safety, and sanitation;

(2) have safety policies and procedures that, at a minimum, address:

(i) safety inspections requiring periodic verification of smoke detectors, carbon monoxide detectors, fire extinguishers, and emergency evacuation drills;

(ii) exposure to bodily fluids and contagious disease; and

(iii) emergency procedures posted in conspicuous locations in the residence;

(3) maintain a supply of an opiate antagonist in the home, post information on proper use, and train staff in opiate antagonist use;

(4) have written policies regarding access to all prescribed medications and storage of medications when requested by the resident;

(5) have written policies regarding residency termination, including how length of stay is determined and procedures in case of evictions;

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

(7) ensure separation of money of persons served by the program from money of the program or program staff. The program and staff must not:

(i) borrow money from a person served by the program;

(ii) purchase personal items from a person served by the program;

(iii) sell merchandise or personal services to a person served by the program;

(iv) require a person served by the program to purchase items for which the program is eligible for reimbursement; or

(v) use money of persons served by the program to purchase items for which the program is already receiving public or private payments;

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

(9) maintain contact information for emergency resources in the community, including but not limited to local mental health crisis services and the 988 Lifeline, to address mental health and health emergencies;

(10) have policies on staff qualifications and a prohibition against relationships between operators and residents;

(11) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the FDA for the treatment of opioid use disorder, co-occurring substance use disorders, and mental health conditions;

(12) have a fee schedule and refund policy;

(13) have rules for residents, including on prohibited items;

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

(15) have policies requiring abstinence from alcohol and illicit drugs on the property. If the program utilizes drug screening or toxicology, the procedures must be included in the program's policies;

(16) distribute the recovery resident bill of rights in subdivision 3, resident rules, certification, and grievance process and post the documents in this clause in common areas;

(17) have policies and procedures on person and room searches;

(18) have code of ethics policies and procedures they are aligned with the NARR code of ethics and document that the policies and procedures are read and signed by all those associated with the operation of the recovery residence, including owners, operators, staff, and volunteers;

(19) have a description of how residents are involved with the governance of the residence, including decision-making procedures, how residents are involved in setting and implementing rules, and the role of peer leaders, if any; and

(20) have procedures to maintain a respectful environment, including appropriate action to stop intimidation, bullying, sexual harassment, or threatening behavior of residents, staff, and visitors within the residence. Programs should consider trauma-informed and resilience-promoting practices when determining action.

Subd. 3. **Resident bill of rights.** An individual living in a recovery residence has the right to:

(1) have access to an environment that supports recovery;

(2) have access to an environment that is safe and free from alcohol and other illicit drugs or substances;

(3) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act, sections 626.557 to 626.5572;

(4) be treated with dignity and respect and to have personal property treated with respect;

(5) have personal, financial, and medical information kept private and to be advised of the recovery residence's policies and procedures regarding disclosure of the information;

(6) access while living in the residence to other community-based support services as needed;

(7) be referred to appropriate services upon leaving the residence if necessary;

(8) retain personal property that does not jeopardize the safety or health of the resident or others;

(9) assert the rights in this subdivision personally or have the rights asserted by the individual's representative or by anyone on behalf of the individual without retaliation;

(10) be provided with the name, address, and telephone number of the ombudsman for mental health and developmental disabilities and the commissioner and be provided with information about the right to file a complaint;

(11) be fully informed of the rights and responsibilities in this section and program policies and procedures; and

(12) not be required to perform services for the residence that are not included in the usual expectations for all residents.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 40. **[254B.212] COMPLAINTS AGAINST RECOVERY RESIDENCES.**

Subdivision 1. **In general.** Any complaints about a recovery residence may be made to and reviewed or investigated by the commissioner.

Subd. 2. **Types of complaints.** The commissioner must receive and review complaints that concern:

(1) the health and safety of residents;

(2) management of the recovery residence, including but not limited to house environment, financial procedures, staffing, house rules and regulations, improper handling of resident terminations, and recovery support environment; or

(3) illegal activities or threats.

Subd. 3. **Investigation.** (a) Complaints regarding illegal activities or threats must be immediately referred to law enforcement in the jurisdiction where the recovery residence

is located. The commissioner must continue to investigate complaints under subdivision 2, clause (3), that have been referred to law enforcement unless law enforcement requests the commissioner to stay the investigation.

(b) The commissioner must investigate all other types of complaints under this section and may take any action necessary to conduct an investigation, including but not limited to interviewing the recovery residence operator, staff, and residents and inspecting the premises.

Subd. 4. **Anonymity.** When making a complaint pursuant to this section, an individual must disclose the individual's identity to the commissioner. Unless ordered by a court or authorized by the complainant, the commissioner must not disclose the complainant's identity.

Subd. 5. **Prohibition against retaliation.** A recovery residence owner, operator, director, staff member, or resident must not be subject to retaliation, including but not limited to interference, threats, coercion, harassment, or discrimination for making any complaint against a recovery residence or against a recovery residence owner, operator, or chief financial officer.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 41. **[254B.213] CERTIFICATION.**

Subdivision 1. **Voluntary certification.** The commissioner must establish and provide for the administration of a voluntary certification program based on best practices as outlined by the American Society for Addiction Medicine and the Substance Abuse and Mental Health Services Administration for recovery residences seeking certification under this section.

Subd. 2. **Application requirements.** An applicant for certification must, at a minimum, submit the following documents on forms approved by the commissioner:

(1) if the premises for the recovery residence is leased, documentation from the owner that the applicant has permission from the owner to operate a recovery residence on the premises;

(2) all policies and procedures required under this chapter;

(3) copies of all forms provided to residents, including but not limited to the recovery residence's medication, drug-testing, return-to-use, refund, and eviction or transfer policies;

(4) proof of insurance coverage necessary and, at a minimum:

(i) employee dishonesty insurance in the amount of $10,000 if the vendor has or had custody or control of money or property belonging to clients; and

(ii) bodily injury and property damage insurance in the amount of $2,000,000 for each occurrence; and

(5) proof of completed background checks for the operator and residence staff.

Subd. 3. **Inspection pursuant to application.** Upon receiving a completed application, the commissioner must conduct an initial on-site inspection of the recovery residence to ensure the residence is in compliance with the requirements of sections 254B.21 to 254B.216.

Subd. 4. **Certification.** The commissioner must certify a recovery residence upon approval of the application and after the initial on-site inspection. The certification automatically terminates three years after issuance of the certification if the commissioner does not renew the certification. Upon certification, the commissioner must issue the recovery residence a proof of certification.

Subd. 5. **Display of proof of certification.** A certified recovery residence must publicly display a proof of certification in the recovery residence.

Subd. 6. **Nontransferability.** Certifications issued pursuant to this section cannot be transferred to an address other than the address in the application or to another certification holder without prior approval from the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 42. **[254B.214] MONITORING AND OVERSIGHT OF CERTIFIED RECOVERY RESIDENCES.**

Subdivision 1. **Monitoring and inspections.** (a) The commissioner must conduct an on-site certification review of the certified recovery residence every three years to determine the certification holder's compliance with applicable rules and statutes.

(b) The commissioner must offer the certification holder a choice of dates for an announced certification review. A certification review must occur during regular business hours.

(c) The commissioner must make the results of certification reviews and the results of investigations that result in a correction order publicly available on the department's website.

Subd. 2. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred to the commissioner under this section, if the recovery residence is in

operation and the information is relevant to the commissioner's inspection or investigation, the certification holder must provide the commissioner access to:

(1) the physical facility and grounds where the residence is located;

(2) documentation and records, including electronically maintained records;

(3) residents served by the recovery residence;

(4) staff persons of the recovery residence; and

(5) personnel records of current and former staff of the recovery residence.

(b) The applicant or certification holder must provide the commissioner with access to the facility and grounds, documentation and records, residents, and staff without prior notice and as often as the commissioner considers necessary if the commissioner is conducting an inspection or investigating alleged maltreatment or a violation of a law or rule. When conducting an inspection, the commissioner may request assistance from other state, county, and municipal governmental agencies and departments. The applicant or certification holder must allow the commissioner, at the commissioner's expense, to photocopy, photograph, and make audio and video recordings during an inspection.

Subd. 3. **Correction orders.** (a) If the applicant or certification holder fails to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

(1) the condition that constitutes a violation of the law or rule;

(2) the specific law or rule that the applicant or certification holder has violated; and

(3) the time that the applicant or certification holder is allowed to correct each violation.

(b) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the correction order. An applicant or certification holder must make a request for reconsideration in writing. The request must be sent via electronic communication to the commissioner within 20 calendar days after the applicant or certification holder received the correction order and must:

(1) specify the part of the correction order that is allegedly erroneous;

(2) explain why the specified part is erroneous; and

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

(c) A request for reconsideration does not stay any provision or requirement of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal.

(d) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the certified recovery residence according to subdivision 4.

(e) Nothing in this subdivision prohibits the commissioner from decertifying a recovery residence according to subdivision 4.

Subd. 4. **Decertification.** (a) The commissioner may decertify a recovery residence if a certification holder:

(1) failed to comply with an applicable law or rule; or

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, during an investigation, or regarding compliance with applicable laws or rules.

(b) When considering decertification of a recovery residence, the commissioner must consider 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 residents.

(c) If the commissioner decertifies a recovery residence, the order of decertification must inform the certification holder of the right to have a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The certification holder may appeal the decertification. The certification holder must appeal a decertification in writing and send or deliver the appeal to the commissioner by certified mail or personal service. If the certification holder mails the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar days after the certification holder receives the order of decertification. If the certification holder delivers an appeal by personal service, the commissioner must receive the appeal within ten calendar days after the certification holder received the order. If the certification holder submits a timely appeal of an order of decertification, the certification holder may continue to operate the program until the commissioner issues a final order on the decertification.

(d) If the commissioner decertifies a recovery residence pursuant to paragraph (a), clause (1), based on a determination that the recovery residence was responsible for maltreatment under chapter 260E or section 626.557, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal if the certification

holder appeals the decertification according to paragraph (c) and appeals the maltreatment determination pursuant to chapter 260E or section 626.557.

Subd. 5. **Notifications required and noncompliance.** (a) Changes in recovery residence organization, staffing, services, or quality assurance procedures that affect the ability of the certification holder to comply with the minimum standards of this chapter must be reported in writing by the certification holder to the commissioner, in a manner approved by the commissioner, within 15 days of the occurrence. The commissioner must review the change. If the change would result in noncompliance in minimum standards, the commissioner must give the recovery residence written notice and up to 180 days to correct the areas of noncompliance before being decertified. The recovery residence must develop interim procedures to resolve the noncompliance on a temporary basis and submit the interim procedures in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. The commissioner must immediately decertify a recovery residence that fails to report a change that results in noncompliance within 15 days, fails to develop an approved interim procedure within 30 days of the determination of the noncompliance, or does not resolve the noncompliance within 180 days.

(b) The commissioner may require the recovery residence to submit written information to document that the recovery residence has maintained compliance with this section.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 43. **[254B.215] CERTIFICATION LEVELS.**

Subdivision 1. **Certification levels.** When certifying a recovery residence, the commissioner must specify whether the residence is a level-one or level-two certified recovery residence.

Subd. 2. **Level-one certification.** (a) The commissioner must designate a certified residence as a level-one certified recovery residence when the residence is peer run. A level-one certified recovery residence must:

(1) not permit an allowance for on-site paid staff or operator of the recovery residence;

(2) permit only nonpaid staff to live or work within the residence; and

(3) ensure that decisions are made solely by residents.

(b) Staff of a level-one certified recovery residence must not provide billable peer recovery support services to residents of the recovery residence.

Subd. 3. **Level-two certification.** (a) The commissioner must designate a certified residence as a level-two certified recovery residence when the residence is managed by someone other than the residents. A level-two certified recovery residence must have staff to model and teach recovery skills and behaviors.

(b) A level-two certified recovery residence must:

(1) have written job descriptions for each staff member position, including position responsibilities and qualifications;

(2) have written policies and procedures for ongoing performance development of staff;

(3) provide annual training on emergency procedures, resident bill of rights, grievance policies and procedures, and code of ethics;

(4) provide community or house meetings, peer supports, and involvement in self-help or off-site treatment services;

(5) have identified recovery goals;

(6) maintain documentation that residents are linked with community resources such as job search, education, family services, and health and housing programs; and

(7) maintain documentation of referrals made for additional services.

(c) Staff of a level-two certified recovery residence must not provide billable peer support services to residents of the recovery residence.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 44. **[254B.216] RESIDENT RECORD.**

A certified recovery residence must maintain documentation with a resident's signature stating that each resident received the following prior to or on the first day of residency:

(1) the recovery resident bill of rights in section 254B.211, subdivision 3;

(2) the residence's financial obligations and agreements, refund policy, and payments from third-party payers for any fees paid on the resident's behalf;

(3) a description of the services provided by the recovery residence;

(4) relapse policies;

(5) policies regarding personal property;

(6) orientation to emergency procedures;

(7) orientation to resident rules; and

(8) all other applicable orientation materials identified in sections 254B.21 to 254B.216.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 45. Minnesota Statutes 2024, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from registration and license fee account.** (a) The appropriations in paragraphs (b) to (n) shall be made from the registration and license fee account on a fiscal year basis in the order specified.

(b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be made accordingly.

(c) $100,000 is appropriated to the commissioner of human services for grants for opiate antagonist distribution. Grantees may utilize funds for opioid overdose prevention, community asset mapping, education, and opiate antagonist distribution.

(d) $2,000,000 is appropriated to the commissioner of human services for ~~grants~~ direct payments to Tribal nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce. Any evaluations of practices under this paragraph must be designed cooperatively by the commissioner and Tribal nations or urban Indian communities. The commissioner must not require recipients to provide the details of specific ceremonies or identities of healers.

(e) $400,000 is appropriated to the commissioner of human services for competitive grants for opioid-focused Project ECHO programs.

(f) $277,000 in fiscal year 2024 and $321,000 each year thereafter is appropriated to the commissioner of human services to administer the funding distribution and reporting requirements in paragraph (o).

(g) $3,000,000 in fiscal year 2025 and $3,000,000 each year thereafter is appropriated to the commissioner of human services for safe recovery sites start-up and capacity building grants under section 254B.18.

(h) $395,000 in fiscal year 2024 and $415,000 each year thereafter is appropriated to the commissioner of human services for the opioid overdose surge alert system under section 245.891.

(i) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

(j) $261,000 is appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph (n).

(k) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(l) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(m) After the appropriations in paragraphs (b) to (l) are made, 50 percent of the remaining amount is appropriated to the commissioner of children, youth, and families for distribution to county social service agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide prevention and child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to county social service agencies and Tribal social service agency initiative projects through a formula based on intake data from the previous three calendar years related to substance use and out-of-home placement episodes where parental drug abuse is a reason for the out-of-home placement. County social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide prevention and child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

(n) After the appropriations in paragraphs (b) to (m) are made, the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

(o) Beginning in fiscal year 2022 and each year thereafter, funds for county social service agencies and Tribal social service agency initiative projects under paragraph (m) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (n) may be distributed on a calendar year basis.

(p) Notwithstanding section 16A.28, subdivision 3, funds appropriated in paragraphs (c), (d), (e), (g), (m), and (n) are available for three years after the funds are appropriated.

Sec. 46. Minnesota Statutes 2024, section 256B.0625, subdivision 5m, as amended by Laws 2025, chapter 20, section 208, 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 30, 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. 47. Minnesota Statutes 2024, section 256B.0757, subdivision 4c, is amended to read:

Subd. 4c. **Behavioral health home services staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a licensed nurse, as defined in section 148.171, subdivision 9.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional who is qualified according to section 245I.04, subdivision 2.

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner who is qualified according to section 245I.04, subdivision 4, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

(2) a mental health certified family peer specialist who is qualified according to section 245I.04, subdivision 12;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14;

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section ~~245G.07, subdivision 1, clause (5)~~ 245G.11, subdivision 8; or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

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. 48. 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~~;~~, except 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. 49. Minnesota Statutes 2024, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph (b), an agency may not enter into an agreement with an establishment to provide housing support unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02, subdivision 4a, as a community residential setting by the commissioner of human services; ~~or~~

(3) the facility is licensed under chapter 144G and provides three meals a day~~.~~; or

(4) effective January 1, 2027, the establishment is licensed by the Department of Health as a board and lodging establishment and is certified by the commissioner as a recovery residence in accordance with section 254B.215, subdivision 3, that is subject to the requirements of section 256I.04, subdivisions 2a to 2f. The Department of Human Services must serve as the lead agency for agreements entered into under this clause.

(b) The requirements under paragraph (a) do not apply to establishments exempt from state licensure because they are:

(1) located on Indian reservations and subject to tribal health and safety requirements; or

(2) supportive housing establishments where an individual has an approved habitability inspection and an individual lease agreement.

(c) Supportive housing establishments that serve individuals who have experienced long-term homelessness and emergency shelters must participate in the homeless management information system and a coordinated assessment system as defined by the commissioner.

(d) Effective July 1, 2016, an agency shall not have an agreement with a provider of housing support unless all staff members who have direct contact with recipients:

(1) have skills and knowledge acquired through one or more of the following:

(i) a course of study in a health- or human services-related field leading to a bachelor of arts, bachelor of science, or associate's degree;

(ii) one year of experience with the target population served;

(iii) experience as a mental health certified peer specialist according to section 256B.0615; or

(iv) meeting the requirements for unlicensed personnel under sections 144A.43 to 144A.483;

(2) hold a current driver's license appropriate to the vehicle driven if transporting recipients;

(3) complete training on vulnerable adults mandated reporting and child maltreatment mandated reporting, where applicable; and

(4) complete housing support orientation training offered by the commissioner.

Sec. 50. Minnesota Statutes 2024, section 325F.725, is amended to read:

325F.725 ~~SOBER HOME~~ RECOVERY RESIDENCE TITLE PROTECTION.

No person or entity may use the phrase ~~"sober home,"~~ "recovery residence," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity meets the definition of a ~~sober home~~ recovery residence in section 254B.01, subdivision 11, and meets the requirements of ~~section 254B.181~~ sections 254B.21 to 254B.216.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 51. **RECOVERY RESIDENCE WORK GROUP.**

(a) The commissioner of human services must convene a work group to develop recommendations specific to recovery residences. The work group must:

(1) produce a report that examines how other states fund recovery residences, identifying best practices and models that could be applicable to Minnesota;

(2) engage with stakeholders to ensure meaningful collaboration with key external stakeholders on the ideas being developed that will inform the final plan and recommendations; and

(3) create an implementable plan addressing housing needs for individuals in outpatient substance use disorder treatment that includes:

(i) clear strategies for aligning housing models with individual treatment needs;

(ii) an assessment of funding streams, including potential federal funding sources;

(iii) a timeline for implementation with key milestones and action steps;

(iv) recommendations for future resource allocation to ensure long-term housing stability for individuals in recovery;

(v) specific recommendations for policy or legislative changes that may be required to support sustainable recovery housing solutions, including challenges faced by recovery residences resulting from state and local housing regulations and ordinances; and

(vi) recommendations for potentially delegating the commissioner's recovery residence certification duties under Minnesota Statutes, sections 254B.21 to 254B.216 to a third-party organization.

(b) The work group must include but is not limited to:

(1) at least two designees from the Department of Human Services representing: (i) behavioral health; and (ii) homelessness and housing and support services;

(2) the commissioner of health or a designee;

(3) two people who have experience living in a recovery residence;

(4) representatives from at least three substance use disorder lodging facilities currently operating in Minnesota;

(5) three representatives from county social services agencies, at least one from inside the seven-county metropolitan area and one from outside the seven-county metropolitan area;

(6) a representative from a Tribal social services agency;

(7) representatives from the state affiliate of the National Alliance for Recovery Residences; and

(8) representatives from state mental health advocacy and adult mental health provider organizations.

(c) The work group must meet at least monthly and as necessary to fulfill its responsibilities. The commissioner of human services must provide administrative support and meeting space for the work group. The work group may conduct meetings remotely.

(d) The commissioner of human services must make appointments to the work group by October 1, 2025, and convene the first meeting of the work group by January 15, 2026.

(e) The work group must submit a final report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before January 1, 2027.

Sec. 52. **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. 53. **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. 54. **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. 55. **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. 56. **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. 57. **REPEALER.**

(a) Minnesota Statutes 2024, section 254B.01, subdivision 5, is repealed.

(b) Minnesota Statutes 2024, section 254B.04, subdivision 2a, is repealed.

(c) Minnesota Statutes 2024, section 254B.181, is repealed.

(d) Minnesota Statutes 2024, sections 245G.01, subdivision 20d; and 245G.07, subdivision 2, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2026, paragraph (b) is effective July 1, 2027, paragraph (c) is effective January 1, 2027, and paragraph (d) is effective July 1, 2026, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

ARTICLE 5
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2024, section 246.54, subdivision 1a, is amended to read:

Subd. 1a. **Anoka-Metro Regional Treatment Center.** (a) A county's payment of the cost of care provided at Anoka-Metro Regional Treatment Center shall be according to the following schedule:

(1) zero percent for the first 30 days;

(2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate for the client; and

(3) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged.

(b) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for days over 31 for clients who meet the criteria in paragraph (a), clause (2), the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

~~(c) Between July 1, 2023, and March 31, 2025, the county is not responsible for the cost of care under paragraph (a), clause (3), for a person who is committed as a person who has a mental illness and is dangerous to the public under section 253B.18 and who is awaiting transfer to another state-operated facility or program. This paragraph expires March 31, 2025.~~

~~(d) Between April 1, 2025, and June 30, 2025, The county is not responsible for the cost of care under paragraph (a), clause (3), for a person who is civilly committed, if the client is awaiting transfer:~~

~~(1) to a facility operated by the Department of Corrections; or~~

~~(2) to another state-operated facility or program, and the Direct Care and Treatment executive medical director's office or a designee has determined that:~~

~~(i) the client meets criteria for admission to that state-operated facility or program; and~~

~~(ii) the state-operated facility or program is the only facility or program that can reasonably serve the client. This paragraph expires June 30, 2025.~~

~~(e)~~ (c) Notwithstanding any law to the contrary, the client is not responsible for payment of the cost of care under this subdivision.

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

Sec. 2. Minnesota Statutes 2024, section 246.54, subdivision 1b, is amended to read:

Subd. 1b. **Community behavioral health hospitals.** (a) A county's payment of the cost of care provided at state-operated community-based behavioral health hospitals for adults and children shall be ~~according to the following schedule:~~

~~(1)~~ 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged~~; and~~.

~~(2)~~ (b) The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

~~(b) Between July 1, 2023, and March 31, 2025, the county is not responsible for the cost of care under paragraph (a), clause (1), for a person committed as a person who has a mental illness and is dangerous to the public under section 253B.18 and who is awaiting transfer to another state-operated facility or program. This paragraph expires March 31, 2025.~~

~~(c) Between April 1, 2025, and June 30, 2025, The county is not responsible for the cost of care under paragraph (a), clause (1), for a person who is civilly committed, if the client is awaiting transfer:~~

~~(1) to a facility operated by the Department of Corrections; or~~

~~(2) to another state-operated facility or program, and the Direct Care and Treatment executive medical director's office or a designee has determined that:~~

~~(i) the client meets criteria for admission to that state-operated facility or program; and~~

~~(ii) the state-operated facility or program is the only facility or program that can reasonably serve the client. This paragraph expires June 30, 2025.~~

~~(d)~~ (c) Notwithstanding any law to the contrary, the client is not responsible for payment of the cost of care under this subdivision.

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

Sec. 3. Minnesota Statutes 2024, section 246C.07, is amended by adding a subdivision to read:

Subd. 9. **Public notice of admission metrics.** (a) By January 1, 2026, the Direct Care and Treatment executive board must publish on the agency's website a publicly accessible dashboard regarding referrals under section 253B.10, subdivision 1, paragraph (b).

(b) The dashboard required under paragraph (a) must include data on:

(1) how many individuals are on the wait lists;

(2) the length of the shortest, longest, and average wait times for admission to Direct Care and Treatment facilities;

(3) the number of referrals, admissions, and wait lists and the length of time individuals have spent on wait lists; and

(4) framework categories and referral sources.

(c) Any published data must be de-identified.

(d) Data on the dashboard is public data under section 13.03.

(e) The executive board must update the dashboard quarterly.

(f) The executive board must also include relevant admissions policies and contact information for the Direct Care and Treatment central preadmissions office on the agency's website.

(g) The executive board must provide information about an individual's relative placement on the wait list to the individual or the individual's legal representative, consistent with section 13.04. Information about the individual's relative placement on the wait list must be designated as confidential under section 13.02, subdivision 3, if the information jeopardizes the health or well-being of the individual.

Sec. 4. Minnesota Statutes 2024, section 253B.10, subdivision 1, as amended by Laws 2025, chapter 38, article 3, section 41, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The executive board shall prioritize civilly committed patients being admitted from jail or a correctional institution or who are referred to a state-operated treatment facility for competency attainment or a competency examination under sections 611.40 to 611.59 for admission to a medically appropriate state-operated direct care and treatment bed based on the decisions of physicians in the executive medical director's office, using a priority admissions framework. The framework must account for a range of factors for priority admission, including but not limited to:

(1) the length of time the person has been on a waiting list for admission to a state-operated direct care and treatment program since the date of the order under paragraph (a), or the date of an order issued under sections 611.40 to 611.59;

(2) the intensity of the treatment the person needs, based on medical acuity;

(3) the person's revoked provisional discharge status;

(4) the person's safety and safety of others in the person's current environment;

(5) whether the person has access to necessary or court-ordered treatment;

(6) distinct and articulable negative impacts of an admission delay on the facility referring the individual for treatment; and

(7) any relevant federal prioritization requirements.

Patients described in this paragraph must be admitted to a state-operated treatment program within the timelines specified in section 253B.1005. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (d). Patients committed to a secure treatment facility or less restrictive setting as ordered by the court under section 253B.18, subdivisions 1 and 2, must be prioritized for admission to a state-operated treatment program using the priority admissions framework in this paragraph.

(c) Upon the arrival of a patient at the designated treatment facility, state-operated treatment program, or community-based treatment program, the head of the facility or

program shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the facility or program.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the prepetition report, and any medical and behavioral information available shall be provided at the time of admission of a patient to the designated treatment facility or program to which the patient is committed. Upon a patient's referral to the executive board for admission pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or correctional facility that has provided care or supervision to the patient in the previous two years shall, when requested by the treatment facility or executive board, provide copies of the patient's medical and behavioral records to the executive board for purposes of preadmission planning. This information shall be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws.

(e) Within four business days of determining which state-operated direct care and treatment program or programs are appropriate for an individual, the executive medical ~~director's office~~ director or a designee must notify the source of the referral and the responsible county human services agency, the individual being ordered to direct care and treatment, and the district court that issued the order of the determination. The initial notice shall include ~~which program or programs are appropriate for the person's priority status~~ the individual's relative priority status by quartile and contact information for the Direct Care and Treatment central preadmissions office. Detailed information on factors impacting the individual's priority status is available from the central preadmissions office upon request, consistent with section 13.04. Any interested person or the individual being ordered to direct care and treatment may provide additional information to or request updated priority status about the individual ~~to~~ from the executive medical ~~director's office~~ director or a designee while the individual is awaiting admission. ~~Updated~~ Priority status ~~of~~ information for an individual will only be disclosed to interested persons who are legally authorized to receive private information about the individual, including the designated agency and the facility to which the individual is awaiting admission. Specific updated priority status information may be withheld from the individual being ordered to direct care and treatment if, in the judgment of the physicians in the executive medical director's office, the information will jeopardize the individual's health or well-being. ~~When an available bed has been identified,~~

~~the executive medical director's office or a designee must notify the designated agency and the facility where the individual is awaiting admission that the individual has been accepted for admission to a particular state-operated direct care and treatment program and the earliest possible date the admission can occur. The designated agency or facility where the individual is awaiting admission must transport the individual to the admitting state-operated direct care and treatment program no more than 48 hours after the offered admission date.~~

(f) For any individual not admitted to a state-operated direct care and treatment program within 60 business days after the initial notice under paragraph (e), the executive medical director or a designee must provide additional notice to the responsible county human services agency, the individual being ordered to direct care and treatment, and the district court that issued the order of the determination. The additional notice must include updates to the same information provided in the previous notice.

(g) When an available bed has been identified, the executive medical director or a designee must notify the designated agency and the facility where the individual is awaiting admission that the individual has been accepted for admission to a particular state-operated direct care and treatment program and the earliest possible date the admission can occur. The designated agency or facility where the individual is awaiting admission must transport the individual to the admitting direct care and treatment program no more than 48 hours after the offered admission date.

Sec. 5. Minnesota Statutes 2024, section 256G.08, subdivision 1, is amended to read:

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

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

Sec. 6. Minnesota Statutes 2024, section 256G.08, subdivision 2, is amended to read:

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

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

Sec. 7. Minnesota Statutes 2024, section 256G.09, subdivision 1, is amended to read:

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

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

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

Sec. 8. Minnesota Statutes 2024, section 256G.09, subdivision 2, as amended by Laws 2025, chapter 21, section 54, is amended to read:

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

(b) The initially responsible county then has 15 calendar days to submit its position and any supporting evidence to the commissioner of human services. The absence of a submission

by the initially responsible county does not limit the right of the commissioner of human services; the commissioner of children, youth, and families; or Direct Care and Treatment executive board to issue a binding opinion based on the evidence actually submitted.

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

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

Sec. 9. Minnesota Statutes 2024, section 611.43, is amended by adding a subdivision to read:

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

(b) The Direct Care and Treatment executive board shall determine the cost of confinement in a state-operated treatment facility based on the executive board's determination of cost of care pursuant to section 246.50, subdivision 5.

Sec. 10. Laws 2024, chapter 125, article 6, section 1, subdivision 7, is amended to read:

Subd. 7. **Expiration.** Subdivisions 1 to 3 expire June 30, 2027. Subdivision 4 ~~expire~~ expires June 30, 2026. Subdivisions 5 and 6 expire upon submission by the Direct Care and Treatment executive board of the report to the legislature required under subdivision 5.

Sec. 11. **PRIORITY ADMISSIONS REVIEW PANEL.**

Subdivision 1. **Establishment.** The Priority Admissions Review Panel is established.

Subd. 2. **Membership; compensation.** (a) The review panel consists of the following members:

(1) one member appointed by the governor;

(2) the commissioner of human services, or a designee;

(3) one representative of Direct Care and Treatment, who has experience with civil commitments, appointed by the Direct Care and Treatment executive medical director's office;

(4) the ombudsman for mental health and developmental disabilities;

(5) one hospital representative, appointed by the Minnesota Hospital Association;

(6) one county representative, appointed by the Association of Minnesota Counties;

(7) one county social services representative, appointed by the Minnesota Association of County Social Service Administrators;

(8) one member appointed by the Hennepin County Commitment Defense Project;

(9) one county attorney, appointed by the Minnesota County Attorneys Association;

(10) one county sheriff, appointed by the Minnesota Sheriffs' Association;

(11) one member appointed by the Minnesota Psychiatric Society;

(12) one member appointed by the Minnesota Association of Community Mental Health Programs;

(13) one member appointed by the National Alliance on Mental Illness Minnesota;

(14) the Minnesota attorney general or a designee;

(15) three individuals from organizations representing racial and ethnic groups that are overrepresented in the criminal justice system, appointed by the commissioner of corrections;

(16) one member of the public with lived experience directly related to the review panel's purposes, appointed by the governor; and

(17) one member who has an active role as a union representative representing staff at Direct Care and Treatment appointed by joint representatives of the 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).

(b) Individuals currently serving as members of the Priority Admissions Review Panel established under Laws 2024, chapter 125, article 4, section 7, may continue to serve as

members of the Priority Admissions Review Panel. Any new appointments must be made no later than September 1, 2025.

(c) Member compensation and reimbursement for expenses are governed by Minnesota Statutes, section 15.059, subdivision 3.

(d) A member of the legislature must not serve as a member of the Priority Admissions Review Panel.

Subd. 3. **Officers; meetings.** (a) The attorney general and the commissioner of human services or their designees must serve as co-chairs. The review panel may elect other officers as necessary.

(b) Review panel meetings are subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 4. **Administrative support.** Direct Care and Treatment must provide administrative support and staff assistance for the review panel.

Subd. 5. **Data usage and privacy.** Any data provided by executive agencies as part of the work and report of the review panel is subject to the requirements of the Minnesota Government Data Practices Act under Minnesota Statutes, chapter 13, and all other applicable data privacy laws.

Subd. 6. **Duties.** The panel must:

(1) evaluate the 48-hour timelines for priority admissions required under Minnesota Statutes, section 253B.1005, and measure progress toward implementing the recommendations of the Task Force on Priority Admissions to State-Operated Treatment Programs;

(2) develop policy and legislative proposals related to the priority admissions timeline that minimize litigation costs, maximize capacity in and access to direct care and treatment programs, and address issues related to individuals awaiting admission to direct care and treatment programs in jails and correctional institutions;

(3) evaluate existing mobile crisis programs and funding and make recommendations to improve access to mobile crisis services in Minnesota;

(4) evaluate the county correctional facility long-acting injectable antipsychotic medication pilot program established in Laws 2024, chapter 125, article 4, section 12, and the Direct Care and Treatment county correctional facility support pilot program established

in Laws 2024, chapter 125, article 8, section 2, subdivision 20, paragraph (c), and make recommendations related to the continuation of the pilot programs;

(5) evaluate existing intensive residential treatment services and make recommendations to improve access to intensive residential treatment services;

(6) study local fiscal impacts and provide evaluation support consistent with Minnesota Statutes, section 16A.055, subdivision 1a, of the limited capacity in and access to state-operated treatment programs, non-state-operated treatment programs, competency evaluation services, and competency attainment services; and

(7) review quarterly data provided by the executive board to measure the impact of changes, including:

(i) priority admission wait list data, including the time each individual spends on the wait list;

(ii) data regarding engagement by the admissions team;

(iii) priority notice data; and

(iv) other similar data relating to admissions.

Subd. 7. **Report.** By February 1, 2026, the review panel must submit a written report to the chairs and ranking minority members of the legislative committees with jurisdiction over public safety and human services that includes the results of the panel's evaluations and study, and any legislative proposals to carry out the recommendations developed under subdivision 6.

Sec. 12. **DIRECTION FOR LIMITED EXCEPTION FOR ADMISSIONS FROM HOSPITAL SETTINGS.**

(a) The commissioner of human services or a designee must immediately approve an exception to add up to ten patients per fiscal year who have been civilly committed and are in hospital settings to the admission wait list for medically appropriate direct care and treatment beds under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b).

(b) The Direct Care and Treatment executive board is subject to the requirement under paragraph (a) upon and after the transfer of duties on July 1, 2025, from the commissioner of human services to the executive board under Minnesota Statutes, section 246C.04.

(c) This section expires June 30, 2027.

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

ARTICLE 6

EIDBI REFORM

Section 1. **[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 January 1, 2026, the commissioner shall begin issuing provisional licenses to agencies enrolled under chapter 256B to provide EIDBI services.

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

(c) Beginning June 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 May 31, 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 suspended or revoked.

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

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

(2) investigate reports of maltreatment;

(3) investigate complaints against EIDBI 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, 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 denied or the agency's provisional license has been suspended or revoked; and

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

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

Sec. 2. Minnesota Statutes 2024, section 245C.03, subdivision 15, is amended to read:

Subd. 15. **Early intensive developmental and behavioral intervention providers.** The commissioner shall conduct background studies according to this chapter ~~when initiated by an~~ on any individual who is an owner with at least a five percent ownership stake in, an operator of, or an employee or volunteer who provides direct contact for early intensive developmental and behavioral intervention ~~provider~~ services under section 256B.0949. For the purposes of this subdivision, operator includes board members or other individuals who oversee the billing, management, or policies of the services provided.

Sec. 3. Minnesota Statutes 2024, section 245C.04, is amended by adding a subdivision to read:

Subd. 12. **Early intensive developmental and behavioral intervention providers.** Providers required to initiate background studies under section 245C.03, subdivision 15, must initiate a study using the electronic system known as NETStudy 2.0 before the individual begins in a position allowing direct contact with persons served by the provider or before the individual becomes an operator or acquires five percent or more ownership.

Sec. 4. Minnesota Statutes 2024, section 245C.13, subdivision 2, is amended to read:

Subd. 2. **Activities pending completion of background study.** The subject of a background study may not perform any activity requiring a background study under paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

(a) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245C.17 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual affiliated with a Title IV-E eligible children's residential facility or foster residence setting, the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

(2) a notice that a disqualification has been set aside under section 245C.23; or

(3) a notice that a variance has been granted related to the individual under section 245C.30.

(b) For a background study affiliated with a licensed child care center or certified license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must require the individual to be under continuous direct supervision prior to completion of the background study except as permitted in subdivision 3.

(c) Activities prohibited prior to receipt of notice under paragraph (a) include:

(1) being issued a license;

(2) living in the household where the licensed program will be provided;

(3) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision;

(4) having access to persons receiving services if the background study was completed under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2), (5), or (6), unless the subject is under continuous direct supervision;

(5) for licensed child care centers and certified license-exempt child care centers, providing direct contact services to persons served by the program;

(6) for children's residential facilities or foster residence settings, working in the facility or setting; ~~or~~

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study of the personal care assistant under this chapter and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

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

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22~~.~~; or

(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:

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

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

EFFECTIVE DATE. This section is effective August 5, 2025.

Sec. 5. 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. 6. 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. 7. 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.~~ "Behavior analyst" means an individual licensed under sections 148.9981 to 148.9995 as a behavior analyst.

(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 of an agency" or "employee" means any individual who is employed temporarily, part time, or full time by the agency that is submitting claims or billing for the work, services, supervision, or treatment performed by the individual. Employee does not

include an independent contractor, billing agency, or consultant who is not providing EIDBI services. Employee does not include an individual who performs work, provides services, supervises, or provides treatment for less than 80 hours in a 12-month period.

~~(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.

(q) "Person" means an individual under 21 years of age.

~~(p)~~ (r) "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)~~ (s) "Qualified EIDBI provider" means ~~a person~~ an individual 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. 8. 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. 9. 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 agency and be:

(1) either a licensed mental health professional ~~who has~~ or a licensed behavior analyst, and 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

(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~~ meet one of the following requirements:

(i) have 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) have 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) be 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) be 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~~.~~;

(v) have a bachelor's degree from an accredited college or university in behavioral health, child development, or a related field; have at least 6,000 hours of clinical experience providing early intervention services in the modality the EIDBI agency uses; and have completed the EIDBI level III provider training requirements; or

(vi) be currently enrolled or have completed a master's degree program at an accredited college or university in behavioral health, child development, or a related field and receive intervention observation and direction from a qualified supervising professional at least monthly until having completed 2,000 hours of supervised clinical experience.

(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~~.~~;

(6) a person currently enrolled in a bachelor's degree program at an accredited college or university in behavioral health, child development, or a related field who receives intervention observation and direction from a QSP or level I provider at least twice monthly until having completed 1,000 hours of supervised clinical experience; or

(7) a person who is at least 18 years of age, holds a current certification in the treatment modality of the EIDBI agency, receives intervention observation and direction from a provider with an advance certification at least weekly until having completed 1,000 hours of supervised clinical experience, and has completed the level III EIDBI training requirements.

(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. 10. 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 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 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 agency, have completed the level III training requirement, be at least 18 years of age, and have at least one of the following:

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

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

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

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

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

Sec. 11. 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 16 hours of direct treatment per person, unless otherwise authorized in the person's individual treatment plan; and

(16) provide required EIDBI intervention observation and direction at least once per month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention observation and direction under this clause may be conducted via telehealth provided that no more than two consecutive monthly required EIDBI intervention observation and direction 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 who do not provide EIDBI services; and

(3) provide copies of any contracts with consultants or independent contractors who do not provide EIDBI services, 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 January 1, 2026.

Sec. 12. Minnesota Statutes 2024, section 256B.0949, subdivision 16a, is amended to read:

Subd. 16a. **Background studies.** (a) 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~~ chapter 245C and must maintain documentation of background study requests and results.

(b) Before an individual subject to the background study requirements under this subdivision has direct contact with a person served by the provider, 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. 13. 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. 14. Minnesota Statutes 2024, section 260E.14, subdivision 1, as amended by Laws 2025, chapter 20, section 221, 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 Human Services 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 July 1, 2025.

Sec. 15. 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. 16. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DEVELOPMENT OF COMPREHENSIVE EIDBI LICENSE.**

(a) By January 1, 2026, the commissioner of human services must collaborate with the Early Intensive Developmental and Behavioral Advisory Council to develop 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 advisory council 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 midpoint billing practices;

(7) measures of clinical effectiveness;

(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; and

(9) the continuation or modification of existing exceptions under Minnesota Statutes, section 256B.0949, subdivision 17.

(b) 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. 17. **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 of human services 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 before July 1, 2025.

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

Sec. 18. **EXISTING EIDBI EXCEPTIONS.**

Exceptions to the requirements of Minnesota Statutes, section 256B.0949, authorized under Minnesota Statutes, section 256B.0949, subdivision 17, in effect on June 30, 2025, must remain in effect until full implementation of a new comprehensive EIDBI license under Minnesota Statutes, chapter 245A.

Sec. 19. **REPEALER.**

Minnesota Statutes 2024, section 256B.0949, subdivision 9, is repealed.

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

ARTICLE 7
HOMELESSNESS, HOUSING, AND SUPPORT SERVICES

Section 1. Minnesota Statutes 2024, section 245C.03, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities and providers of housing stabilization services.** (a) ~~The commissioner shall conduct background studies of any individual who provides direct contact, as defined in section 245C.02, subdivision 11,~~ For providers of services specified in the federally approved home and community-based waiver plans under section 256B.4912 and providers of housing stabilization services under section 256B.051, the commissioner shall conduct background studies on any individual who is an owner with at least a five percent ownership stake in the provider, an operator of the provider, or an employee or volunteer for the provider who has direct contact with people receiving the services. The individual studied must meet the requirements of this chapter prior to providing waiver services and as part of ongoing enrollment.

(b) The requirements in paragraph (a) apply to consumer-directed community supports under section 256B.4911.

(c) For purposes of this section, "operator" includes but is not limited to a managerial officer who oversees the billing, management, or policies of the services provided.

Sec. 2. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to read:

Subd. 16. **Providers of recuperative care.** The commissioner shall conduct background studies on any individual who is an owner with an ownership stake of at least five percent in a recuperative care provider, an operator of a recuperative care provider, or an employee

or volunteer who has direct contact with people receiving recuperative care services under section 256B.0701.

EFFECTIVE DATE. This section is effective upon implementation in NETStudy 2.0 or January 13, 2026, whichever is later. The commissioner of human services shall notify the revisor of statutes when the commissioner implements the changes in NETStudy 2.0.

Sec. 3. Minnesota Statutes 2024, section 245C.04, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities and providers of housing stabilization services.** (a) Providers required to initiate background studies under section ~~256B.4912~~ 245C.03, subdivision 6, must initiate a study using the electronic system known as NETStudy 2.0 before the individual begins in a position allowing direct contact with persons served by the provider. New providers must initiate a study under this subdivision before initial enrollment if the provider has not already initiated background studies as part of the service licensure requirements.

(b) Except as provided in paragraphs (c) and (d), the providers must initiate a background study annually of an individual required to be studied under section 245C.03, subdivision 6.

(c) After an initial background study under this subdivision is initiated on an individual by a provider of both services licensed by the commissioner and the unlicensed services under this subdivision, a repeat annual background study is not required if:

(1) the provider maintains compliance with the requirements of section 245C.07, paragraph (a), regarding one individual with one address and telephone number as the person to receive sensitive background study information for the multiple programs that depend on the same background study, and that the individual who is designated to receive the sensitive background information is capable of determining, upon the request of the commissioner, whether a background study subject is providing direct contact services in one or more of the provider's programs or services and, if so, at which location or locations; and

(2) the individual who is the subject of the background study provides direct contact services under the provider's licensed program for at least 40 hours per year so the individual will be recognized by a probation officer or corrections agent to prompt a report to the commissioner regarding criminal convictions as required under section 245C.05, subdivision 7.

~~(d) A provider who initiates background studies through NETStudy 2.0 is exempt from the requirement to initiate annual background studies under paragraph (b) for individuals who are on the provider's active roster.~~

Sec. 4. Minnesota Statutes 2024, section 245C.04, is amended by adding a subdivision to read:

Subd. 13. **Recuperative care providers.** Providers required to initiate background studies under section 245C.03, subdivision 16, must initiate a study using the electronic system known as NETStudy 2.0 before the individual begins in a position allowing direct contact with persons served by the provider, before the individual becomes an operator of the provider, or before the individual acquires an ownership interest of at least five percent in the provider.

Sec. 5. Minnesota Statutes 2024, section 245C.10, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities and providers of housing stabilization services.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 and providers of housing stabilization services under section 256B.051 through a fee of no more than $44 per study.

Sec. 6. Minnesota Statutes 2024, section 245C.10, is amended by adding a subdivision to read:

Subd. 22. **Recuperative care providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 16, for recuperative care under section 256B.0701, through a fee of no more than $44 per study charged to the enrolled provider. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 7. 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) provider under this subdivision at least once every five years; and (2) personal care assistance agency under this subdivision once every three years.

(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.051, 256B.0659, 256B.0701, or 256B.85.

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

Sec. 8. Minnesota Statutes 2024, section 256B.051, subdivision 2, is amended to read:

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

(b) "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 housing stabilization services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section.

~~(b)~~ (c) "At-risk of homelessness" means (1) an individual that is faced with a set of circumstances likely to cause the individual to become homeless, or (2) an individual previously homeless, who will be discharged from a correctional, medical, mental health, or treatment center, who lacks sufficient resources to pay for housing and does not have a permanent place to live.

~~(c)~~ (d) "Commissioner" means the commissioner of human services.

(e) "Employee of an agency" or "employee" means any person who is employed by an agency temporarily, part time, or full time and who performs work for at least 80 hours in a year for that agency in Minnesota. Employee does not include an independent contractor.

~~(d)~~ (f) "Homeless" means an individual or family lacking a fixed, adequate nighttime residence.

~~(e)~~ (g) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria used by the title 11 program of the Social Security Act, United States Code, title 42, section 416, paragraph (i), item (1); or

(2) an individual who meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

~~(f)~~ (h) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause (3), and the Minnesota Security Hospital as defined in section 253.20.

Sec. 9. Minnesota Statutes 2024, section 256B.051, subdivision 5, is amended to read:

Subd. 5. **Housing stabilization services.** (a) Housing stabilization services include housing transition services ~~and~~, housing and tenancy sustaining services, housing consultation services, and housing transition costs.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) ~~A housing stabilization service may include~~ Housing consultation services assist an individual with developing a person-centered ~~planning for people who are~~ plan when the individual is not eligible to receive person-centered planning through any other service~~, if the person-centered planning is provided by a consultation service provider that is under contract with the department and enrolled as a Minnesota health care program~~.

(e) Housing transition costs are available to persons transitioning from a provider-controlled setting to the person's own home and include:

(1) security deposits; and

(2) essential furnishings and supplies.

Sec. 10. Minnesota Statutes 2024, section 256B.051, subdivision 6, is amended to read:

Subd. 6. **~~Provider~~ Agency qualifications and duties.** ~~A provider~~ An agency is eligible for reimbursement under this section ~~shall~~ only if the agency:

(1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 6a;

~~(1) enroll~~ (2) is enrolled as a medical assistance Minnesota health care program provider and ~~meet~~ meets all applicable provider standards and requirements;

~~(2) demonstrate~~ (3) demonstrates compliance with federal and state laws and policies for housing stabilization services as determined by the commissioner;

~~(3) comply~~ (4) complies with background study requirements under chapter 245C and ~~maintain~~ maintains documentation of background study requests and results;

(5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location

providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is $300,000 or less, the provider agency must purchase a surety bond of $50,000. If the provider's medical assistance revenue in the previous year is over $300,000, the provider agency 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. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

~~(4)~~ (6) directly ~~provide~~ provides housing stabilization services using employees of the agency and not ~~use~~ by using a subcontractor or reporting agent; ~~and~~

~~(5) complete~~ (7) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training~~.~~; and

(8) completes compliance training as required under subdivision 6b.

Sec. 11. Minnesota Statutes 2024, section 256B.051, is amended by adding a subdivision to read:

Subd. 6a. **Pre-enrollment risk assessment.** (a) Prior to enrolling a housing stabilization services agency, the commissioner must complete a pre-enrollment risk assessment of the agency seeking to enroll to confirm the agency's eligibility and the agency's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential agency's history of performing services similar to those required by this section;

(2) whether the services require the potential agency to perform duties at a significantly increased scale and, if so, whether the potential agency has the capability and organizational capacity to do so;

(3) the potential agency's financial information and internal controls; and

(4) the potential agency's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential agency does not have a history of performing similar duties, the potential agency does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential agency ineligible and deny or rescind enrollment. A potential agency may appeal a decision regarding its eligibility in writing within 30 business days. The commissioner must notify each potential agency of the commissioner's final decision regarding its eligibility.

(c) This subdivision is effective July 1, 2025. Any housing stabilization services provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Sec. 12. Minnesota Statutes 2024, section 256B.051, is amended by adding a subdivision to read:

Subd. 6b. **Requirements for provider enrollment.** (a) Effective January 1, 2027, to enroll as a housing stabilization services provider agency, an agency must require all owners of the agency who are active in the day-to-day management and operations of the agency and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) enrollment requirements;

(3) provider program integrity, including fraud prevention, detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the agency. If an individual moves to another housing stabilization services provider agency

and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any housing stabilization services provider agency enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

Sec. 13. Minnesota Statutes 2024, section 256B.051, subdivision 8, is amended to read:

Subd. 8. **Documentation requirements.** (a) ~~Documentation may be collected and maintained~~ An agency must document delivery of all services. The agency must collect and maintain the required information either electronically or in paper form ~~by providers~~ and must ~~be produced~~ produce the documents containing the information upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the full name of the service recipient;

~~(1)~~ (2) the date the documentation occurred;

~~(2)~~ (3) the day, month, and year the service was provided;

~~(3)~~ (4) the start and stop times with a.m. and p.m. designations, except for ~~person-centered planning services described under subdivision 5, paragraph (d)~~ housing consultation services;

~~(4)~~ (5) the service name or description of the service provided for each date of service; ~~and~~

~~(5)~~ (6) the name, signature, and title, if any, of the ~~provider of~~ employee of the agency that provided the service. If the service is provided by multiple ~~staff members~~ employees, the ~~provider~~ agency may designate ~~a staff member~~ an employee responsible for verifying services and completing the documentation required by this paragraph~~.~~;

(7) the signature of the service recipient and a statement that the recipient's signature is verification of the accuracy of the service documentation; and

(8) a statement that it is a federal crime to provide false information on housing stabilization services billings for medical assistance payments.

Sec. 14. Minnesota Statutes 2024, section 256B.051, is amended by adding a subdivision to read:

Subd. 9. **Service limits.** (a) Housing stabilization services must not exceed the limits in clauses (1) to (4):

(1) housing transition services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing and tenancy sustaining services;

(2) housing and tenancy sustaining services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing transition services;

(3) housing consultation services are available once annually per recipient and must be provided in person. Additional sessions of housing consultation services may be authorized by the commissioner if the recipient becomes homeless, the recipient experiences a significant change in condition that impacts the recipient's housing, or the recipient requests an update or change to the recipient's plan; and

(4) housing transition costs are limited to $3,000 annually.

(b) Remote support cannot be used for more than a total of 20 percent of all housing transition services and housing and tenancy sustaining services provided to a recipient in a calendar month and is limited to audio-only and accessible video-based platforms. A recipient may refuse, stop, or suspend the use of remote support at any time.

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. 15. Minnesota Statutes 2024, section 256B.051, is amended by adding a subdivision to read:

Subd. 10. **Service limit exceptions.** If a recipient requires services exceeding the limits described in subdivision 9, a provider may request authorization for additional hours in a format prescribed by the commissioner. Requests must specify the number of additional hours being requested to meet the recipient's needs and include sufficient documentation to justify the increase to billable hours. Exceptions to service limits are not allowed on the sole basis of changing providers and are limited to recipients who:

(1) become or are at risk of becoming homeless or institutionalized due to a significant change in condition;

(2) have a history of long-term homelessness;

(3) have a history of domestic violence; or

(4) have a criminal background that is a barrier to obtaining housing.

EFFECTIVE DATE. This section is effective January 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. 16. Minnesota Statutes 2024, section 256B.0701, subdivision 1, is amended to read:

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

(b) "Habitability inspection" means an inspection that meets the requirements of subdivision 13.

~~(b)~~ (c) "Provider" means a recuperative care provider ~~as defined by~~ that meets the standards ~~established~~ for medical respite care programs most recently published by the National Institute for Medical Respite Care.

~~(c)~~ (d) "Recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized or remain hospitalized, or to need other levels of care.

Sec. 17. Minnesota Statutes 2024, section 256B.0701, subdivision 2, is amended to read:

Subd. 2. **Recuperative care settings.** Recuperative care may be provided in any setting that meets the habitability inspection requirements in subdivision 13, including but not limited to homeless shelters, congregate care settings, single room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

(1) 24-hour access to a bed and bathroom;

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

(5) a secure place to store belongings; and

(6) staff available within the setting to provide a wellness check as needed, but at a minimum, at least once every 24 hours.

Sec. 18. Minnesota Statutes 2024, section 256B.0701, is amended by adding a subdivision to read:

Subd. 9. **Provider qualifications and duties.** A provider is eligible for reimbursement under this section only if the provider:

(1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 10;

(2) is enrolled as a medical assistance Minnesota health care program provider and meets all applicable provider standards and requirements;

(3) demonstrates compliance with federal and state laws and policies for housing stabilization services as determined by the commissioner;

(4) complies with background study requirements under chapter 245C and maintains documentation of background study requests and results;

(5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is $300,000 or less, the provider agency must purchase a surety bond of $50,000. If the provider's medical assistance revenue in the previous year is over $300,000, the provider agency 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. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training;

(7) completes compliance training as required under subdivision 11; and

(8) complies with the habitability inspection requirements in subdivision 13.

Sec. 19. Minnesota Statutes 2024, section 256B.0701, is amended by adding a subdivision to read:

Subd. 10. **Pre-enrollment risk assessment.** (a) Prior to enrolling a recuperative care provider, the commissioner must complete a pre-enrollment risk assessment of the provider seeking to enroll to confirm the provider's eligibility and the provider's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential provider's history of performing services similar to those required by this section;

(2) whether the services require the potential provider to perform duties at a significantly increased scale and, if so, whether the potential provider has the capability and organizational capacity to do so;

(3) the potential provider's financial information and internal controls; and

(4) the potential provider's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential provider does not have a history of performing similar duties, the potential provider does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential provider ineligible and deny or rescind enrollment. A potential provider may appeal a decision regarding the provider's eligibility in writing within 30 business days. The commissioner must notify each potential provider of the commissioner's final decision regarding the provider's eligibility.

(c) This subdivision is effective July 1, 2025. Any recuperative care provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Sec. 20. Minnesota Statutes 2024, section 256B.0701, is amended by adding a subdivision to read:

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners

of the provider who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) enrollment requirements;

(3) provider program integrity, including fraud prevention, detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the provider and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the provider. If an individual moves to another recuperative care provider and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any recuperative care provider enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

Sec. 21. Minnesota Statutes 2024, section 256B.0701, is amended by adding a subdivision to read:

Subd. 12. **Requirements for provider enrollment; documentation of habitability inspection.** (a) Effective July 1, 2025, to enroll as a recuperative care provider, a provider must submit to the commissioner proof that a habitability inspection of the proposed service setting has been performed and a qualified inspector has deemed the setting habitable.

(b) Any recuperative care provider enrolled prior to July 1, 2025, must submit to the commissioner by July 1, 2026, proof that a habitability inspection of the service setting has been performed and a qualified inspector has deemed the setting habitable.

Sec. 22. Minnesota Statutes 2024, section 256B.0701, is amended by adding a subdivision to read:

Subd. 13. **Habitability inspection requirements.** (a) A recuperative care provider providing recuperative care services in an unlicensed setting must ensure that the unlicensed setting is inspected by a qualified inspector with demonstrated knowledge of housing inspection standards and professional experience conducting home inspections. The habitability inspection must include an assessment of potential home-based health and safety risks to ensure the living environment does not adversely affect the occupants' health and safety. Inspectors must evaluate both the habitability and environmental safety of the property, including but not limited to the following characteristics of the unlicensed setting:

(1) adequacy of space for the individuals being served;

(2) indoor air quality and ventilation;

(3) adequacy of safe water supply;

(4) cleanliness of the setting, including kitchen, bathroom, and living spaces;

(5) adequacy of electrical service, outlets, and lighting and absence of electrical hazards;

(6) potential lead exposure;

(7) conditions that may affect health;

(8) conditions that may affect safety;

(9) condition of the building foundation and exterior, including accessibility; and

(10) condition and functionality of equipment for heating, cooling, and ventilation and plumbing.

(b) A recuperative care provider must not provide services in an unlicensed setting prior to receiving a habitability inspection and documentation that the inspector deems the setting habitable. The recuperative care provider must maintain documentation that the inspection occurred and the results of the inspection.

Sec. 23. Minnesota Statutes 2024, section 256I.05, is amended by adding a subdivision to read:

Subd. 1v. **Supplementary rate for certain facilities.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2026, an agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1 for a housing support provider operating indoor communities with low barriers to access. The communities must: (1) be composed

of individual secure, private dwellings for persons experiencing unsheltered homelessness with complex health needs including substance use disorder, serious mental illness, and physical health conditions; and (2) provide 24-hour-a-day supervision with on-site support services for 100 beds in the Twin Cities metropolitan area in a facility operating since 2020 and 48 beds in central Minnesota in a facility opening after 2025. The supplementary rate must not exceed $975 per month, including any legislatively authorized inflationary adjustments.

Sec. 24. Minnesota Statutes 2024, section 256I.05, is amended by adding a subdivision to read:

Subd. 1w. **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. 25. Minnesota Statutes 2024, section 256I.05, is amended by adding a subdivision to read:

Subd. 1x. **Supplemental rate; Otter Tail County.** Notwithstanding the provisions of subdivisions 1a and 1c, 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.

Sec. 26. **REPEALER.**

Minnesota Statutes 2024, sections 245C.03, subdivision 13; and 245C.10, subdivision 16, are repealed.

ARTICLE 8

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 providers or assisted living facilities.

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 facilities 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.** 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~~ is appropriated to the commissioner for ~~special projects to improve~~ a competitive grant program for special projects or initiatives for assisted living facilities licensed under this chapter or other organizations or entities with experience in or knowledge of assisted living operations, compliance, resident needs, or best practices for the purpose of improving resident quality of care and outcomes in assisted living facilities licensed under this chapter in Minnesota ~~as recommended by the advisory council established in section 144A.4799.~~, including those projects consistent with criteria in section 144A.4799, subdivision 3, paragraph (c). A facility with a provisional license under this chapter 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. 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.

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. **Nursing home.** "Nursing home" means a facility licensed as a nursing home under chapter 144A.

Subd. 4. **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 OF CERTAIN ACQUISITIONS OF NURSING HOMES AND ASSISTED LIVING FACILITIES.**

Subdivision 1. **Notice.** 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 commissioner of health and the commissioner of human services of its intent to transfer ownership or control to a for-profit entity.

Subd. 2. **Information.** 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 to the attorney general, commissioner of health, and commissioner of human services 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.

EFFECTIVE DATE. This section is effective July 1, 2025, and applies to transfers of ownership or control occurring on or after July 1, 2025.

Sec. 15. Minnesota Statutes 2024, section 256B.092, subdivision 1a, as amended by Laws 2025, chapter 38, article 1, section 16, 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 facilities 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, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. 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. 16. Minnesota Statutes 2024, section 256B.49, subdivision 13, as amended by Laws 2025, chapter 38, article 1, section 18, 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~~.~~<u>; and</u>

<u>(6) assisting and cooperating with facilities licensed under chapter 144G with the licensee's obligations under section 144G.55.</u>

(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, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. 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.

ARTICLE 9
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 144.0724, subdivision 11, as amended by Laws 2025, chapter 38, article 2, section 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. Laws 2024, chapter 125, article 4, 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. 3. Laws 2024, chapter 125, article 4, 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. 4. Laws 2024, chapter 125, article 4, 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. 5. Laws 2024, chapter 125, article 4, section 9, subdivision 9, is amended to read:

Subd. 9. **Expiration.** The task force expires January 1, ~~2026~~ 2027.

Sec. 6. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the term "emotional disturbance" or similar terms to "mental illness" or similar terms wherever the terms appear in Minnesota Statutes. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

ARTICLE 10
DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY

Section 1. Minnesota Statutes 2024, section 245A.03, is amended by adding a subdivision to read:

Subd. 7a. **Discretionary temporary licensing moratorium.** (a) The commissioner must not accept an application from or issue an initial license for an individual, organization, or government entity seeking licensure under this chapter and must not add a new service to an existing license when the commissioner determines that exceptional growth in applications for licensure or requests to add new services exceeds the determined need for service capacity. The determined need for service capacity may be limited to a specific region, service focus, or other factors as determined by the commissioner. A temporary licensing moratorium issued under this subdivision is effective for a period of up to 24 months from the date the commissioner issues the moratorium.

(b) Any applicant that will not receive a license due to a temporary licensing moratorium issued under paragraph (a) may apply for a refund of licensing application fees for up to one year from the date the commissioner issues the moratorium.

(c) The commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services at least 30 days prior to issuing a temporary moratorium under this subdivision and publish notice of the moratorium on the department's website. The notice must include:

(1) a list of all license types to which the moratorium will apply;

(2) the proposed start date of the moratorium; and

(3) the anticipated duration of the moratorium.

(d) The commissioner must establish and make publicly available the processes and criteria the commissioner will use to grant exceptions to a temporary moratorium issued under this subdivision.

Sec. 2. Minnesota Statutes 2024, section 245A.04, subdivision 7, as amended by Laws 2025, chapter 38, article 5, section 6, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license, and the specific service the license holder is licensed to provide;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the observation required by subdivision 4, paragraph (a), clause (3), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program.

(d) Except as provided in paragraphs (i) and (j), the commissioner shall not issue a license if the applicant, license holder, or an affiliated controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license under this chapter or chapter 142B within the past two years;

(3) had a license issued under this chapter or chapter 142B revoked within the past five years; or

(4) failed to submit the information required of an applicant under subdivision 1, paragraph (f), (g), or (h), after being requested by the commissioner.

When a license issued under this chapter or chapter 142B is revoked, the license holder and each affiliated controlling individual with a revoked license may not hold any license under chapter 245A for five years following the revocation, and other licenses held by the applicant or license holder or licenses affiliated with each controlling individual shall also be revoked.

(e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license affiliated with a license holder or controlling individual that had a license revoked within the past five years if the commissioner determines that (1) the license holder or controlling individual is operating the program in substantial compliance with applicable laws and rules and (2) the program's continued operation is in the best interests of the community being served.

(f) Notwithstanding paragraph (d), the commissioner may issue a new license in response to an application that is affiliated with an applicant, license holder, or controlling individual that had an application denied within the past two years or a license revoked within the past five years if the commissioner determines that (1) the applicant or controlling individual has operated one or more programs in substantial compliance with applicable laws and rules and (2) the program's operation would be in the best interests of the community to be served.

(g) In determining whether a program's operation would be in the best interests of the community to be served, the commissioner shall consider factors such as the number of persons served, the availability of alternative services available in the surrounding community, the management structure of the program, whether the program provides culturally specific services, and other relevant factors.

(h) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

(i) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a

temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

(j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

(k) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must comply with the requirements in section 245A.10 and be reissued a new license to operate the program or the program must not be operated after the expiration date. Adult foster care, family adult day services, child foster residence setting, and community residential services license holders must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

(l) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a Tribal licensing authority has established jurisdiction to license the program or service.

(m) The commissioner of human services may coordinate and share data with the commissioner of children, youth, and families to enforce this section.

(n) For substance use disorder treatment programs, for the purposes of paragraph (a), clause (5), the maximum number of persons who may receive services from the program includes persons served at satellite locations.

EFFECTIVE DATE. This section is effective July 1, 2025, except paragraph (n), which is effective January 1, 2026.

Sec. 3. Minnesota Statutes 2024, section 245A.043, is amended by adding a subdivision to read:

Subd. 2a. **Review of change in ownership.** (a) After a change in ownership under subdivision 2, paragraph (a), the commissioner may complete a review for all new license holders within 12 months after the new license is issued.

(b) For all license holders subject to the exception in subdivision 2, paragraph (b), the license holder must notify the commissioner of the date of the change in controlling individuals pursuant to section 245A.04, subdivision 7a, and the commissioner may complete a review within 12 months following the change.

Sec. 4. Minnesota Statutes 2024, section 245A.10, subdivision 1, is amended to read:

Subdivision 1. **Application or license fee required~~; programs exempt from fee.~~** ~~(a) Unless exempt under paragraph (b),~~ The commissioner shall charge a fee for evaluation of applications and inspection of programs which are licensed under this chapter.

~~(b) Except as provided under subdivision 2, no application or license fee shall be charged for a child foster residence setting, adult foster care, or a community residential setting.~~

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

Sec. 5. Minnesota Statutes 2024, section 245A.10, subdivision 2, is amended to read:

Subd. 2. **~~County fees for applications and licensing inspections~~ Application or license inspection fee required; programs with county oversight.** ~~(a)~~ For purposes of adult foster care and child foster residence setting licensing, family adult day services, family adult foster care, and licensing the physical plant of a community residential setting or residential services facility, under this chapter, ~~a county agency may~~ the commissioner shall charge a fee to a ~~corporate applicant or corporate~~ license holder ~~to recover the actual cost~~ for the evaluation of ~~licensing~~ licenses and inspections~~, not to exceed $500~~ of programs in the amount of $2,100 annually.

~~(b) Counties may elect to reduce or waive the fees in paragraph (a) under the following circumstances:~~

~~(1) in cases of financial hardship;~~

~~(2) if the county has a shortage of providers in the county's area; or~~

~~(3) for new providers.~~

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

Sec. 6. Minnesota Statutes 2024, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) Except as provided in paragraphs (c) and (d), for fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a ~~$500~~ $2,100 application fee with each new application required under this subdivision. ~~An applicant for an initial day services facility license under chapter 245D shall submit a $250 application fee with each new application.~~ The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

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

(c) For a license to provide home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application to provide services statewide. For fees required under subdivision 1, an applicant for an initial license issued by the commissioner to provide home and community-based services under chapter 245D shall submit a $4,200 application fee with each new application.

(d) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner for children's residential facility or mental health clinic licensure or certification shall submit a $500 application fee with each new application required under this subdivision.

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

Sec. 7. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to read:

Subd. 3a. **Fee for change of ownership exception.** (a) A license holder must submit a fee of $2,100 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(b) License holders under chapter 245D must submit a fee of $4,200 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(c) A license holder for a children's residential facility must submit a fee of $500 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

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

Sec. 8. Minnesota Statutes 2024, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
	~~$200~~
less than or equal to $10,000	$250
greater than $10,000 but less than or equal to $25,000	~~$300~~ $375
greater than $25,000 but less than or equal to $50,000	~~$400~~ $500
greater than $50,000 but less than or equal to $100,000	~~$500~~ $625
greater than $100,000 but less than or equal to $150,000	~~$600~~ $750
greater than $150,000 but less than or equal to $200,000	~~$800~~ $1,000
greater than $200,000 but less than or equal to $250,000	~~$1,000~~ $1,250
greater than $250,000 but less than or equal to $300,000	~~$1,200~~ $1,500
greater than $300,000 but less than or equal to $350,000	~~$1,400~~ $1,750
greater than $350,000 but less than or equal to $400,000	~~$1,600~~ $2,000
greater than $400,000 but less than or equal to $450,000	~~$1,800~~ $2,250
greater than $450,000 but less than or equal to $500,000	~~$2,000~~ $2,500
greater than $500,000 but less than or equal to $600,000	~~$2,250~~ $2,850
greater than $600,000 but less than or equal to $700,000	~~$2,500~~ $3,200
greater than $700,000 but less than or equal to $800,000	~~$2,750~~ $3,600
greater than $800,000 but less than or equal to $900,000	~~$3,000~~ $3,900

greater than $900,000 but less than or equal to $1,000,000	~~$3,250~~ $4,250
greater than $1,000,000 but less than or equal to $1,250,000	~~$3,500~~ $4,550
greater than $1,250,000 but less than or equal to $1,500,000	~~$3,750~~ $4,900
greater than $1,500,000 but less than or equal to $1,750,000	~~$4,000~~ $5,200
greater than $1,750,000 but less than or equal to $2,000,000	~~$4,250~~ $5,500
greater than $2,000,000 but less than or equal to $2,500,000	~~$4,500~~ $5,900
greater than $2,500,000 but less than or equal to $3,000,000	~~$4,750~~ $6,200
greater than $3,000,000 but less than or equal to $3,500,000	~~$5,000~~ $6,500
greater than $3,500,000 but less than or equal to $4,000,000	~~$5,500~~ $7,200
greater than $4,000,000 but less than or equal to $4,500,000	~~$6,000~~ $7,800
greater than $4,500,000 but less than or equal to $5,000,000	~~$6,500~~ $9,000
greater than $5,000,000 but less than or equal to $7,500,000	~~$7,000~~ $10,000
greater than $7,500,000 but less than or equal to $10,000,000	~~$8,500~~ $14,000
greater than $10,000,000 but less than or equal to $12,500,000	~~$10,000~~ $18,000
greater than $12,500,000 but less than or equal to $15,000,000	~~$14,000~~ $25,000
greater than $15,000,000 but less than or equal to $17,500,000	~~$18,000~~ $28,000
greater than $17,500,000 but less than $20,000,000	$32,000
greater than $20,000,000 but less than $25,000,000	$36,000
greater than $25,000,000 but less than $30,000,000	$45,000
greater than $30,000,000 but less than $35,000,000	$55,000
greater than $35,000,000	$75,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(b) A substance use disorder treatment program licensed under chapter 245G, to provide substance use disorder treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
	~~$600~~
1 to 24 persons	$2,600
	~~$800~~
25 to 49 persons	$3,000
	~~$1,000~~
50 to 74 persons	$5,000
	~~$1,200~~
75 to 99 persons	$10,000
	~~$1,400~~
100 ~~or more persons~~ to 199 persons	$15,000
200 or more persons	$20,000

(c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
	~~$760~~
1 to 24 persons	$2,600
	~~$960~~
25 to 49 persons	$3,000
	~~$1,160~~
50 or more persons	$5,000

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000

25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
	~~$2,525~~
1 to 24 persons	$2,600
	~~$2,725~~
25 ~~or more persons~~ to 49 persons	$3,000
50 or more persons	$20,000

(f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(g) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	~~$500~~ $2,600
25 to 49 persons	~~$700~~ $3,000
50 to 74 persons	~~$900~~ $5,000
75 to 99 persons	~~$1,100~~ $10,000
100 ~~or more persons~~ to 199 persons	~~$1,300~~ $15,000
200 or more persons	$20,000

(h) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(i) A mental health clinic certified under section 245I.20 shall pay an annual nonrefundable certification fee of $1,550. If the mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

(j) If a program subject to annual fees under paragraph (b) provides services at a primary location with satellite facilities, the satellite facilities must be licensed with the primary location and must be subject to an additional $500 annual nonrefundable license fee per satellite facility.

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

Sec. 9. Minnesota Statutes 2024, section 245A.10, subdivision 8, is amended to read:

Subd. 8. **Deposit of license fees.** A human services licensing and program integrity account is created in the state government special revenue fund. Fees collected under subdivisions 2, 3, and 4 must be deposited in the human services licensing and program integrity account and are annually appropriated to the commissioner for licensing activities authorized under this chapter and program integrity activities.

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

Sec. 10. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to read:

Subd. 8a. **Deposit of county-delegated licensing application fees; appropriation.** Notwithstanding the provisions of any other law, the commissioner shall deposit 50 percent of the fees collected pursuant to subdivision 2 for adult foster care, child foster residence settings, family adult day services, family adult foster care, and licensing the physical plant of a community residential setting or residential services facility into the human services licensing and program integrity account and 50 percent to the credit of the county licensing account in the special revenue fund of each county.

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

Sec. 11. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to read:

Subd. 8b. **Distribution to county; appropriation.** On a quarterly basis, the amount determined under subdivision 8a is appropriated to the commissioner to issue a payment

from the county licensing account in favor of the treasurer of each county for which the commissioner collected a fee under subdivision 2.

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

ARTICLE 11

FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2023, chapter 70, article 20, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2025" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2025.

		APPROPRIATIONS
		Available for the Year
		Ending June 30
		2025

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$** **114,527,000**

Appropriations by Fund

	2025
General	136,895,000
Health Care Access	(16,968,000)
Federal TANF	(5,400,000)

Subd. 2. **Forecasted Programs**

(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**

Appropriations by Fund

	2025
General	(5,951,000)
Federal TANF	(5,400,000)

(b) **MFIP Child Care Assistance** (62,336,000)

(c) **General Assistance** 3,737,000

(d) **Minnesota Supplemental Aid** 3,428,000

(e) **Housing Support** 11,923,000

(f) **MinnesotaCare** (16,525,000)

This appropriation is from the health care access fund.

(g) **Medical Assistance**

Appropriations by Fund	
	2025
General	59,692,000
Health Care Access	(443,000)

(h) **Behavioral Health Fund** 135,928,000

(i) **Northstar Care for Children** (9,526,000)

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

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**	**$ 7,793,334,000**	**$ 7,974,209,000**

Subdivision 1. **Appropriations by Fund**

	Appropriations by Fund	
	2026	2027
General	7,791,601,000	7,972,476,000
Lottery Prize	1,733,000	1,733,000

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 funds 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 MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services deems necessary. Any unexpended balance in the appropriation for these projects does not

cancel and is available for ongoing development and operations.

Sec. 3. **CENTRAL OFFICE; OPERATIONS** **$ 7,273,000 $ 7,000,000**

Subdivision 1. **Budget and Legislative Staff**

$805,000 in fiscal year 2026 and $955,000 in fiscal year 2027 are for additional budget and legislative staff, at least five of whom must be full time. 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. **Self-Directed Bargaining Agreement; IT Matching Systems**

$475,000 in fiscal year 2026 and $990,000 in fiscal year 2027 are to hire a vendor to identify an alternative system to replace the current IT matching registry. The commissioner must include two union representatives to be part of the vendor selection process, which includes involvement in writing request for proposal requirements. This is a onetime appropriation and is available until June 30, 2027.

Subd. 3. **Base Level Adjustment**

The general fund base for this section is $5,396,000 in fiscal year 2028 and $5,210,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE** **$ 1,075,000 $ 1,237,000**

Sec. 5. **CENTRAL OFFICE; AGING AND DISABILITY SERVICES** **$ 10,561,000 $ 8,291,000**

Subdivision 1. **Self-Directed Bargaining Agreement; Health Care Study**

$300,000 in fiscal year 2026 is for a study to examine health care options for individual providers. 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. **Budget and Legislative Analysis**

$458,000 in fiscal year 2026 and $540,000 in fiscal year 2027 are for three additional full-time staff solely supporting budget and legislative analysis work. 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. The general fund base for this appropriation is $546,000 in fiscal year 2028 and $546,000 in fiscal year 2029. This subdivision does not expire.

Subd. 5. **Long-Term Services and Supports Advisory Council**

$1,000,000 in fiscal year 2026 is for administration of the long-term services and supports advisory council, including but not limited to providing administrative support, facilitation, research and data analysis, staffing, and council member compensation. This is a onetime appropriation and is available until June 30, 2028.

Subd. 6. **Base Level Adjustment**

The general fund base for this section is $5,178,000 in fiscal year 2028 and $2,882,000 in fiscal year 2029.

Sec. 6. **CENTRAL OFFICE; BEHAVIORAL HEALTH** **$ 1,377,000** **$ 2,026,000**

Subdivision 1. **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. 2. **Base Level Adjustment**

The general fund base for this section is $2,050,000 in fiscal year 2028 and $2,050,000 in fiscal year 2029.

Sec. 7. **CENTRAL OFFICE; HOMELESSNESS, HOUSING, AND SUPPORT SERVICES** **$ 1,632,000** **$ 780,000**

Subdivision 1. **Minnesota Homeless Study**

$1,200,000 in fiscal year 2026 is for a contract with the Amherst H. Wilder Foundation for activities directly related to the triennial Minnesota homeless study. This is a onetime

appropriation and is available until June 30, 2028.

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $825,000 in fiscal year 2028 and $825,000 in fiscal year 2029.

Sec. 8. **CENTRAL OFFICE; OFFICE OF INSPECTOR GENERAL** **$ 7,781,000 $ 10,636,000**

Base Level Adjustment

The general fund base for this section is $10,893,000 in fiscal year 2028 and $10,893,000 in fiscal year 2029.

Sec. 9. **FORECASTED PROGRAMS; HOUSING SUPPORT** **$ 323,000 $ 3,855,000**

Sec. 10. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE** **$ 7,455,980,000 $ 7,688,985,000**

Boundary Waters Care Center

$250,000 in fiscal year 2026 is for the Boundary Waters Care Center in Ely. This is a onetime appropriation and must be paid without federal matching money.

Sec. 11. **FORECASTED PROGRAMS; ALTERNATIVE CARE** **$ 55,694,000 $ 56,312,000**

Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Sec. 12. **FORECASTED PROGRAMS; BEHAVIORAL HEALTH FUND** **$ 140,025,000 $ 123,347,000**

Sec. 13. **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. 14. **GRANT PROGRAMS; HEALTH CARE GRANTS** **$ 225,000** **$ -0-**

Culturally Responsive Health Access Grant

$225,000 in fiscal year 2026 is for a grant to a minority-led clinic to deliver evidence-based, culturally responsive, and holistic health services. The grant is intended to improve health care access, eliminate barriers to care, and advance health literacy in underserved communities. This is a onetime appropriation and is available until June 30, 2028.

Sec. 15. **GRANT PROGRAMS; OTHER LONG-TERM CARE GRANTS** **$ 2,897,000** **$ 2,075,000**

Subdivision 1. **Health Awareness Hub Pilot Project**

$150,000 in fiscal year 2026 and $150,000 in fiscal year 2027 are for a grant to an organization serving Liberians in Minnesota for a health awareness hub pilot project. The pilot project must address health care education and the physical and mental wellness needs of elderly individuals within the African immigrant community by offering culturally relevant support, resources, and preventive care education from medical practitioners with a similar background and by making appropriate referrals to culturally competent programs, supports, and medical care. This is a onetime appropriation and is available until June 30, 2028.

Subd. 2. **Base Level Adjustment**

The general fund base for this appropriation is $1,925,000 in fiscal year 2028 and $1,925,000 in fiscal year 2029.

Sec. 16. **GRANT PROGRAMS; AGING AND ADULT SERVICES GRANTS** **$ 39,766,000 $ 39,767,000**

Subdivision 1. **Senior Nutrition Programs**

$250,000 in fiscal year 2026 and $250,000 in fiscal year 2027 are for senior nutrition programs under Minnesota Statutes, section 256.9752. The base for this appropriation is $751,000 in fiscal year 2028 and $752,000 in fiscal year 2029.

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $40,268,000 in fiscal year 2028 and $40,269,000 in fiscal year 2029.

Sec. 17. **DEAF, DEAFBLIND, AND HARD OF HEARING GRANTS** **$ 2,886,000 $ 2,886,000**

Sec. 18. **GRANT PROGRAMS; DISABILITY GRANTS** **$ 65,439,000 $ 27,262,000**

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 each collective bargaining unit member for training. This is a onetime appropriation and is available until June 30, 2027.

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 and is available until June 30, 2027.

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. **Base Level Adjustments**

The general fund base for this section is $28,073,000 in fiscal year 2028 and $28,073,000 in fiscal year 2029.

Sec. 19. **GRANT PROGRAMS; ADULT MENTAL HEALTH GRANTS** **$ 600,000 $ -0-**

Subdivision 1. **New Americans Mental Health Grant**

$400,000 in fiscal year 2026 is for a onetime grant to a women-led organization providing services and supports to New Americans in Minneapolis. The grant must be used to support mental health services and supports for adults living with serious mental illness. This is a onetime appropriation and is available until June 30, 2028.

Subd. 2. **Intergenerational Social Service and Health Grant**

$200,000 in fiscal year 2026 is for a grant to a culturally specific, African American-led nonprofit organization based in South Minneapolis that provides intergenerational, family-centered programming rooted in African American traditions. The organization must offer trauma-informed, community-based services that promote family healing, collective resilience, and youth leadership through culturally responsive mental health supports, parent coaching, housing and benefit navigation, and programs that preserve and share ancestral knowledge. This is a onetime appropriation and is available until June 30, 2028.

Sec. 20. **GRANT PROGRAMS; CHILDREN'S MENTAL HEALTH GRANTS** **$ 50,000** **$ -0-**

Youth Development and Leadership Program

$50,000 in fiscal year 2026 is for a grant to an organization serving Ukrainians in Minnesota to support a trauma-informed youth development and leadership program. This is

a onetime appropriation and is available until June 30, 2027.

Sec. 21. **GRANT PROGRAMS; CHEMICAL DEPENDENCY TREATMENT SUPPORT GRANTS** **$ 5,405,000** **$ 5,405,000**

Subdivision 1. **Appropriations by Fund**

Appropriations by Fund	2026	2027
General	3,672,000	3,672,000
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. **Todd County Peer Support Grants**

$150,000 in fiscal year 2026 and $150,000 in fiscal year 2027 are for a grant to an organization in Todd County that provides daily peer support and specialized sessions for individuals in substance use recovery, transitioning out of incarceration, or who have experienced trauma. This is a onetime appropriation and is available until June 30, 2028.

Subd. 4. **Opioid Overdose Crisis Grants**

$175,000 in fiscal year 2026 and $175,000 in fiscal year 2027 are for grants to address the opioid overdose crisis in communities and populations that have been historically underserved and disproportionately impacted by opioid-related overdose deaths. Grant funding must support culturally responsive and community-based strategies that address the intergenerational effects of substance use disorder in African American, Native, and African immigrant communities. This is a onetime appropriation and is available until June 30, 2028.

Subd. 5. **Beltrami Opioid Youth and Family Grant**

$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 opioid epidemic. This is a onetime appropriation and is available until June 30, 2028.

Subd. 6. **Base Level Adjustment**

The general fund base for this section is $3,247,000 in fiscal year 2028 and $3,247,000 in fiscal year 2029.

Sec. 22. 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.

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

Sec. 23. Laws 2023, chapter 61, article 9, section 2, subdivision 14, as amended by Laws 2024, chapter 125, article 8, section 13, is amended to read:

Subd. 14. **Grant Programs; Aging and Adult Services Grants**	164,626,000	34,795,000

(a) **Vulnerable Adult Act Redesign Phase Two.** $17,129,000 in fiscal year 2024 is for adult protection grants to counties and Tribes under Minnesota Statutes, section 256M.42. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. The base for this appropriation is $866,000 in fiscal year 2026 and $867,000 in fiscal year 2027.

(b) **Caregiver Respite Services Grants.** $1,800,000 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.

(c) **Live Well at Home Grants.** $4,575,000 in fiscal year 2024 is for live well at home

grants under Minnesota Statutes, section 256.9754, subdivision 3f. This is a onetime appropriation and is available until June 30, ~~2025~~ 2027.

(d) **Senior Nutrition Program.** $10,552,000 in fiscal year 2024 is for the senior nutrition program. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(e) **Age-Friendly Community Grants.** $3,000,000 in fiscal year 2024 is for the continuation of age-friendly community grants under Laws 2021, First Special Session chapter 7, article 17, section 8, subdivision 1. Notwithstanding Minnesota Statutes, section 16A.28, this is a onetime appropriation and is available until June 30, 2027.

(f) **Age-Friendly Technical Assistance Grants.** $1,725,000 in fiscal year 2024 is for the continuation of age-friendly technical assistance grants under Laws 2021, First Special Session chapter 7, article 17, section 8, subdivision 2. Notwithstanding Minnesota Statutes, section 16A.28, this is a onetime appropriation and is available until June 30, 2027.

(g) **Long-Term Services and Supports Loan Program.** $93,200,000 in fiscal year 2024 is for the long-term services and supports loan program under Minnesota Statutes, section 256R.55, and is available as provided therein.

(h) **Base Level Adjustment.** The general fund base is $33,861,000 in fiscal year 2026 and $33,862,000 in fiscal year 2027.

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

Sec. 24. 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~~ 2027.

(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.

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

Sec. 25. Laws 2023, chapter 61, article 9, section 2, subdivision 17, is amended to read:

Subd. 17. **Grant Programs; Adult Mental Health Grants** 4,400,000 -0-

(a) **Training for Peer Workforce.** $4,000,000 in fiscal year 2024 is for peer workforce training grants. Notwithstanding Minnesota Statutes, section 16A.28, this is a onetime appropriation and is available until June 30, 2027.

(b) **Family Enhancement Center Grant.** $400,000 in fiscal year 2024 is for a grant to the Family Enhancement Center to develop, maintain, and expand community-based social engagement and connection programs to help families dealing with trauma and mental health issues develop connections with each other and their communities, including the NEST parent monitoring program, the cook to connect program, and the call to movement initiative. This appropriation is onetime and is available until June 30, ~~2025~~ 2027.

Sec. 26. Laws 2023, chapter 61, article 9, section 2, subdivision 18, as amended by Laws 2024, chapter 125, article 8, section 15, is amended to read:

Subd. 18. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	54,691,000	5,342,000
Lottery Prize	1,733,000	1,733,000

(a) **Culturally Specific Recovery Community Organization Start-Up Grants.** $4,000,000 in fiscal year 2024 is for culturally specific recovery community organization

start-up grants. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(b) **Safe Recovery Sites.** $14,537,000 in fiscal year 2024 is from the general fund for start-up and capacity-building grants for organizations to establish safe recovery sites. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is onetime and is available until June 30, 2029.

(c) **Technical Assistance for Culturally Specific Organizations; Culturally Specific Services Grants.** $4,000,000 in fiscal year 2024 is for grants to culturally specific providers for technical assistance navigating culturally specific and responsive substance use and recovery programs. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027.

(d) **Technical Assistance for Culturally Specific Organizations; Culturally Specific Grant Development Training.** $400,000 in fiscal year 2024 is for grants for up to four trainings for community members and culturally specific providers for grant writing training for substance use and recovery-related grants. Notwithstanding Minnesota Statutes, section 16A.28, this is a onetime appropriation and is available until June 30, 2027.

(e) **Harm Reduction Supplies for Tribal and Culturally Specific Programs.** $7,597,000 in fiscal year 2024 is from the general fund to provide sole source grants to culturally specific communities to purchase syringes,

testing supplies, and opiate antagonists. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(f) **Families and Family Treatment Capacity-Building and Start-Up Grants.** $10,000,000 in fiscal year 2024 is from the general fund for start-up and capacity-building grants for family substance use disorder treatment programs. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2029. This is a onetime appropriation.

(g) **Start-Up and Capacity Building Grants for Withdrawal Management.** $0 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for start-up and capacity building grants for withdrawal management.

(h) **Recovery Community Organization Grants.** $4,300,000 in fiscal year 2024 is from the general fund for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, that are current grantees as of June 30, 2023. This is a onetime appropriation and is available until June 30, ~~2025~~ 2027.

(i) **Opioid Overdose Prevention Grants.**

(1) $125,000 in fiscal year 2024 and $125,000 in fiscal year 2025 are from the general fund for a grant to Ka Joog, a nonprofit organization in Minneapolis, Minnesota, to be used for collaborative outreach, education, and training on opioid use and overdose, and distribution of opiate antagonist kits in East African and

Somali communities in Minnesota. This is a onetime appropriation.

(2) $125,000 in fiscal year 2024 and $125,000 in fiscal year 2025 are from the general fund for a grant to the Steve Rummler Hope Network to be used for statewide outreach, education, and training on opioid use and overdose, and distribution of opiate antagonist kits. This is a onetime appropriation.

(3) $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are from the general fund for a grant to African Career Education and Resource, Inc. to be used for collaborative outreach, education, and training on opioid use and overdose, and distribution of opiate antagonist kits. This is a onetime appropriation and is available until June 30, 2027.

(j) **Problem Gambling.** $225,000 in fiscal year 2024 and $225,000 in fiscal year 2025 are from the lottery prize fund for a grant to a state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, training for individuals and organizations that provide effective treatment services to problem gamblers and their families, and research related to problem gambling.

(k) **Project ECHO.** $1,310,000 in fiscal year 2024 and $1,295,000 in fiscal year 2025 are from the general fund for a grant to Hennepin Healthcare to expand the Project ECHO program. The grant must be used to establish at least four substance use disorder-focused Project ECHO programs at Hennepin

Healthcare, expanding the grantee's capacity to improve health and substance use disorder outcomes for diverse populations of individuals enrolled in medical assistance, including but not limited to immigrants, individuals who are homeless, individuals seeking maternal and perinatal care, and other underserved populations. The Project ECHO programs funded under this section must be culturally responsive, and the grantee must contract with culturally and linguistically appropriate substance use disorder service providers who have expertise in focus areas, based on the populations served. Grant funds may be used for program administration, equipment, provider reimbursement, and staffing hours. This is a onetime appropriation and is available until June 30, 2027.

(l) **White Earth Nation Substance Use Disorder Digital Therapy Tool.** $3,000,000 in fiscal year 2024 is from the general fund for a grant to the White Earth Nation to develop an individualized Native American centric digital therapy tool with Pathfinder Solutions. This is a onetime appropriation. The grant must be used to:

(1) develop a mobile application that is culturally tailored to connecting substance use disorder resources with White Earth Nation members;

(2) convene a planning circle with White Earth Nation members to design the tool;

(3) provide and expand White Earth Nation-specific substance use disorder services; and

(4) partner with an academic research institution to evaluate the efficacy of the program.

(m) **Wellness in the Woods.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are from the general fund for a grant to Wellness in the Woods for daily peer support and special sessions for individuals who are in substance use disorder recovery, are transitioning out of incarceration, or who have experienced trauma. These are onetime appropriations.

(n) **Base Level Adjustment.** The general fund base is $3,247,000 in fiscal year 2026 and $3,247,000 in fiscal year 2027.

Sec. 27. Laws 2024, chapter 125, article 8, section 2, subdivision 12, is amended to read:

Subd. 12. **Grant Programs; Other Long Term Care Grants**	(2,500,000)	1,962,000

(a) **Health Awareness Hub Pilot Project.** $281,000 in fiscal year 2025 is for a payment to the Organization for Liberians in Minnesota for a health awareness hub pilot project. The pilot project must seek to address health care education and the physical and mental wellness needs of elderly individuals within the African immigrant community by offering culturally relevant support, resources, and preventive care education from medical practitioners who have a similar background, and by making appropriate referrals to culturally competent programs, supports, and medical care. Within six months of the conclusion of the pilot project, the Organization for Liberians in Minnesota must

provide the commissioner with an evaluation of the project as determined by the commissioner. This is a onetime appropriation.

(b) **Chapter 245D Compliance Support.** $219,000 in fiscal year 2025 is for a payment to Black Business Enterprises Fund to support minority providers licensed under Minnesota Statutes, chapter 245D, as intensive support services providers to build skills and the infrastructure needed to increase the quality of services provided to the people the providers serve while complying with the requirements of Minnesota Statutes, chapter 245D, and to enable the providers to accept clients with high behavioral needs. This is a onetime appropriation.

(c) **Customized Living Technical Assistance.** $350,000 is for a payment to Propel Nonprofits for a culturally specific outreach and education campaign toward existing customized living providers that might more appropriately serve their clients under a different home and community-based services program or license. This is a onetime appropriation.

(d) **Linguistically and Culturally Specific Training Pilot Project.** $650,000 in fiscal year 2025 is for a payment to Isuroon to collaborate with the commissioner of human services to develop and implement a pilot program to provide: (1) linguistically and culturally specific in-person training to bilingual individuals, particularly bilingual women, from diverse ethnic backgrounds; and (2) technical assistance to providers to ensure

successful implementation of the pilot program, including training, resources, and ongoing support. Within six months of the conclusion of the pilot project, Isuroon must provide the commissioner with an evaluation of the project as determined by the commissioner. This is a onetime appropriation and is available until June 30, 2027.

(e) **Long-Term Services and Supports Loan Program.** (1) $462,000 in fiscal year 2025 is from the general fund for the long-term services and supports loan program established under Minnesota Statutes, section 256R.55. The base for this appropriation is $822,000 in fiscal year 2026 and $0 in fiscal year 2027.

(2) The commissioner of management and budget shall transfer $462,000 in fiscal year 2025 from the general fund to the long-term services and supports loan account established under Minnesota Statutes, section 256R.55. The base for this transfer is $822,000 in fiscal year 2026 and $0 in fiscal year 2027.

(f) **Base Level Adjustment.** The general fund base is decreased by $1,202,000 in fiscal year 2026 and decreased by $2,024,000 in fiscal year 2027.

Sec. 28. Laws 2024, chapter 125, article 8, 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.

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

Sec. 29. Laws 2024, chapter 125, article 8, section 2, subdivision 14, is amended to read:

Subd. 14. **Grant Programs; Disabilities Grants**	1,650,000	9,574,000

(a) **Capital Improvement for Accessibility.** $400,000 in fiscal year 2025 is for a payment to Anoka County to make capital improvements to existing space in the Anoka County Human Services building in the city of Blaine, including making bathrooms fully compliant with the Americans with Disabilities Act with adult changing tables and ensuring barrier-free access for the purposes of improving and expanding the services an existing building tenant can provide to adults with developmental disabilities. This is a onetime appropriation.

(b) **Dakota County Disability Services Workforce Shortage Pilot Project.** $500,000 in fiscal year 2025 is for a grant to Dakota County for innovative solutions to the

disability services workforce shortage. Up to $250,000 of this amount must be used to develop and test an online application for matching requests for services from people with disabilities to available staff, and up to $250,000 of this amount must be used to develop a communities-for-all program that engages businesses, community organizations, neighbors, and informal support systems to promote community inclusion of people with disabilities. By October 1, 2026, the commissioner shall report the outcomes and recommendations of these pilot projects to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(c) **Pediatric Hospital-to-Home Transition Pilot Program.** $1,040,000 in fiscal year 2025 is for the pediatric hospital-to-home pilot program. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(d) **Artists With Disabilities Support.** $690,000 in fiscal year 2025 is for a payment to a nonprofit organization licensed under Minnesota Statutes, chapter 245D, located on Minnehaha Avenue West in Saint Paul, and that supports artists with disabilities in creating visual and performing art that challenges society's views of persons with disabilities.

This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(e) **Emergency Relief Grants for Rural EIDBI Providers.** $600,000 in fiscal year 2025 is for emergency relief grants for EIDBI providers. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(f) **Self-Advocacy Grants for Persons with Intellectual and Developmental Disabilities.** $250,000 in fiscal year 2025 is for self-advocacy grants under Minnesota Statutes, section 256.477, subdivision 1, paragraph (a), clauses (5) to (7), and for administrative costs. This is a onetime appropriation and is available until June 30, 2027.

(g) **Electronic Visit Verification Implementation Grants.** $864,000 in fiscal year 2025 is for electronic visit verification implementation grants. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(h) **Aging and Disability Services for Immigrant and Refugee Communities.** $250,000 in fiscal year 2025 is for a payment to SEWA-AIFW to address aging, disability, and mental health needs for immigrant and refugee communities. This is a onetime appropriation and is available until June 30, 2027.

(i) **License Transition Support for Small Disability Waiver Providers.** $3,150,000 in fiscal year 2025 is for license transition payments to small disability waiver providers. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(j) **Own home services provider capacity-building grants.** $1,519,000 in fiscal year 2025 is for the own home services provider capacity-building grant program. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(k) **Continuation of Centers for Independent Living HCBS Access Grants.** $311,000 in fiscal year 2024 is for continued funding of grants awarded under Laws 2021, First Special Session chapter 7, article 17, section 19, as amended by Laws 2022, chapter 98, article 15, section 15. This is a onetime appropriation and is available until June 30, 2025.

(l) **Base Level Adjustment.** The general fund base is increased by $811,000 in fiscal year 2026 and increased by $811,000 in fiscal year 2027.

Sec. 30. Laws 2024, chapter 125, article 8, 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.

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

Sec. 31. **ADDITIONAL FEDERAL FUNDING AUTHORITY FOR MINNESOTA BOARD ON AGING.**

Subdivision 1. **Purpose.** This section is for legislative approval to fund additional federal money awarded to the Minnesota Board on Aging for federal grants for fiscal years 2026 and 2027.

Subd. 2. **Older Americans Act Supportive Services grants.** The commissioner of human services is authorized to expend $6,830,000 in fiscal year 2026 and $6,830,000 in fiscal year 2027 for Older Americans Act Supportive Services grants as described in the award notice for Catalog of Federal Domestic Assistance 93.044. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 3. **Older Americans Act Home Delivered Meals award.** The commissioner of human services is authorized to expend $8,099,000 in fiscal year 2026 and $8,099,000 in fiscal year 2027 for Older Americans Act Home Delivered Meals grants as described in the award notice for Catalog of Federal Domestic Assistance 93.045. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 4. **Older Americans Act Elder Abuse Prevention award.** The commissioner of human services is authorized to expend $76,000 in fiscal year 2026 and $76,000 in fiscal year 2027 for Older Americans Act Home Elder Abuse Prevention grants as described in the award notice for Catalog of Federal Domestic Assistance 93.041. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 5. **Minnesota Medical Care Demo Project award.** The commissioner of human services is authorized to expend $580,000 in fiscal year 2026 and $580,000 in fiscal year 2027 for Minnesota Medical Care Demo Project grants as described in the award notice for

Catalog of Federal Domestic Assistance 93.048. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 6. **Older Americans Act Family Caregivers award.** The commissioner of human services is authorized to expend $4,658,000 in fiscal year 2026 and $3,191,000 in fiscal year 2027 for Older Americans Act Family Caregivers grants as described in the award notice for Catalog of Federal Domestic Assistance 93.052. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 7. **Nutrition Services Incentive Program award.** The commissioner of human services is authorized to expend $1,475,000 in fiscal year 2026 and $1,475,000 in fiscal year 2027 for Nutrition Services Incentive Program grants as described in the award notice for Catalog of Federal Domestic Assistance 93.053. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 8. **Older Americans Act Congregate Meals award.** The commissioner of human services is authorized to expend $7,464,000 in fiscal year 2026 and $7,464,000 in fiscal year 2027 for Older Americans Act Congregate Meals grants as described in the award notice for Catalog of Federal Domestic Assistance 93.045. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 9. **Ombudsman supplement award.** The commissioner of human services is authorized to expend $434,000 in fiscal year 2026 and $363,000 in fiscal year 2027 for additional ombudsman supplemental money as described in the award notice for Catalog of Federal Domestic Assistance 93.042. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 10. **Medicare Improvements for Patients and Providers Act Priority 2 award.** The commissioner of human services is authorized to expend $319,000 in fiscal year 2026 and $160,000 in fiscal year 2027 for additional Medicare Improvements for Patients and Providers Act Priority 2 money as described in the award notice for Catalog of Federal Domestic Assistance 93.071. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 11. **Medicare Improvements for Patients and Providers Act Priority 3 award.** The commissioner of human services is authorized to expend $172,000 in fiscal year 2026 and $96,000 in fiscal year 2027 for additional Medicare Improvements for Patients and Providers Act Priority 3 money as described in the award notice for Catalog of Federal Domestic Assistance 93.071. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 12. **American Rescue Plan Act Public Health Workforce award.** The commissioner of human services is authorized to expend $119,000 in fiscal year 2026 and $0 in fiscal year 2027 for additional carryforward authority of American Rescue Plan Act Public Health Workforce money as described in the award notice for Catalog of Federal Domestic Assistance 93.044C. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 13. **American Rescue Plan Act Long Term Care Ombudsman award.** The commissioner of human services is authorized to expend $154,000 in fiscal year 2026 and $40,000 in fiscal year 2027 for additional carryforward authority of American Rescue Plan Act Long Term Care Ombudsman money as described in the award notice for Catalog of Federal Domestic Assistance 93.747C. The total amount authorized over the two years may be spent in either year of the biennium.

Subd. 14. **Adult Protection Elder Justice Act award.** The commissioner of human services is authorized to expend $470,000 in fiscal year 2026 and $241,000 in fiscal year 2027 for additional carryforward authority of Adult Protection Elder Justice Act money as described in the award notice for Catalog of Federal Domestic Assistance 93.698. The total amount authorized over the two years may be spent in either year of the biennium.

Sec. 32. **TRANSFERS AND CANCELLATIONS.**

Subdivision 1. **Local planning grant.** 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. **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. 3. **Chemical dependency peer specialists grant cancellation.** Any unencumbered and unexpended amount of the fiscal year 2025 general fund appropriation for grants for peer specialists first established under Laws 2016, chapter 189, article 23, section 2, subdivision 4, paragraph (f), estimated to be $675,000, is canceled.

Subd. 4. **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. 5. **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. 6. **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. 7. **Opioid overdose prevention grant cancellation.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 18, paragraph (i), clause (1), for opioid overdose prevention activities, estimated to be $96,000, is canceled.

Subd. 8. **Day training and habilitation facility grants.** The fiscal year 2026 and fiscal year 2027 general fund base appropriations 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, are reduced from $811,000 to $0. The general fund base for this purpose is $811,000 in fiscal year 2028 and $811,000 in fiscal year 2029.

Subd. 9. **Transfer from the state government special revenue fund to the general fund.** The commissioner of management and budget must transfer $6,395,000 in fiscal year 2026 and $12,790,000 in fiscal year 2027 from the state government special revenue fund to the general fund. The commissioner of management and budget must include a transfer of $12,790,000 each year from the state government special revenue fund to the general fund in each forecast prepared under Minnesota Statutes, section 16A.103, from the effective date of this subdivision through the February 2027 forecast.

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

Sec. 33. **TRANSFER AUTHORITY.**

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. 34. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, transfer, or cancellation in this article is enacted more than once during the 2025 first special session, the appropriation, transfer, or cancellation must be given effect once.

Sec. 35. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit.

Sec. 36. **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**	**$ 577,459,000**	**$ 602,805,000**

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**

Base Level Adjustments

The general fund base for this section is $194,840,000 in fiscal year 2028 and $236,500,000 in fiscal year 2029. The fiscal year 2029 general fund base includes $41,660,000 to operate the replacement facility for the Miller Building on the Anoka Metro Regional Treatment Center campus. If a bonding appropriation for the replacement for the Miller Building is not enacted during the 2025 first special session, the fiscal year 2029 general fund base is reduced by $41,660,000.

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** **$ 85,482,000 $ 98,350,000**

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. **Base Level Adjustment**

The general fund base for this section is $97,566,000 in fiscal year 2028 and

$101,736,000 in fiscal year 2029. The fiscal year 2029 general fund base includes $4,170,000 for administration and operational support for the replacement facility for the Miller Building on the Anoka Metro Regional Treatment Center campus. If a bonding appropriation for the replacement of the Miller Building is not enacted during a 2025 special session, the fiscal year 2029 general fund base is reduced by $4,170,000.

Sec. 8. Laws 2024, chapter 125, article 8, section 2, subdivision 19, is amended to read:

Subd. 19. **Direct Care and Treatment - Forensic Services**	-0-	7,752,000

(a) **Employee incentives.** $1,000,000 in fiscal year 2025 is for incentives related to the transition of CARE St. Peter to the forensic mental health program. Employee incentive payments under this paragraph must be made to all employees who transitioned from CARE St. Peter to another direct care and treatment program, including employees who transitioned prior to the closure of CARE St. Peter. Employee incentive payments must total $30,000 per transitioned employee, subject to the payment schedule and service requirements in this paragraph. The first incentive payment of $4,000 must be made after the employee has completed six months of service as an employee of another direct care and treatment program, followed by $6,000 at 12 months of completed service, $8,000 at 18 months of completed service, and $12,000 at 24 months of completed service. This is a onetime appropriation and is available until June 30, 2027.

(b) **Base Level Adjustment.** The general fund base is increased by $6,612,000 in fiscal year 2026 and increased by $6,612,000 in fiscal year 2027.

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

Sec. 9. **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. 10. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, transfer, or cancellation in this article is enacted more than once during the 2025 first special session, the appropriation, transfer, or cancellation 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.

ARTICLE 14

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. **COMMISSIONER OF HEALTH; TOTAL APPROPRIATION**	**$ (45,000)**	**$ (247,000)**

The amounts that may be spent for each purpose are specified in the following sections.

Sec. 3. **HEALTH IMPROVEMENT** **$ (250,000) $ (250,000)**

Reductions. The reductions in the fiscal year 2026 and 2027 appropriations in this section are subtracted from appropriations to the commissioner of health for health improvements made in any other law enacted by the 94th legislature during calendar year 2025.

Sec. 4. **HEALTH PROTECTION** **$ 205,000 $ 3,000**

Skin-Lightening Product Awareness. $200,000 in fiscal year 2026 is 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.

Sec. 5. **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 125, article 8, section 4, for the Legislative Task Force on Guardianship, estimated to be $335,000, is canceled.

Sec. 6. **OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 3,706,000 $ 3,765,000**

Sec. 7. **OFFICE OF ADMINISTRATIVE HEARINGS** **$ 272,000 $ 262,000**

Sec. 8. **COMMISSIONER OF ADMINISTRATION** **$ 10,000,000 $ -0-**

Subdivision 1. **Miller Building**

(a) $10,000,000 in fiscal year 2026 is to supplement funds for the demolition, site

preparation, and construction of a replacement facility for the Miller Building on the Anoka Metro Regional Treatment Center campus. The base for this appropriation is $10,000,000 in fiscal year 2028 and $0 in fiscal year 2029. This appropriation and the fiscal year 2028 base, if appropriated, are available until June 30, 2030.

(b) This subdivision expires June 30, 2030.

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $10,000,000 in fiscal year 2028 and $0 in fiscal year 2029.

Sec. 9. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, transfer, or cancellation in this article is enacted more than once during the 2025 first special session, the appropriation, transfer, or cancellation 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.

APPENDIX
Article locations for 25-05696

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

Subd. 13. **Providers of housing stabilization services.** The commissioner shall conduct background studies of any provider of housing stabilization services required by section 256B.051 to have a background study completed under this chapter.

245C.10 BACKGROUND STUDY; FEES.

Subd. 16. **Providers of housing stabilization services.** The commissioner shall recover the cost of background studies initiated by providers of housing stabilization services under section 256B.051 through a fee of no more than $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

245G.01 DEFINITIONS.

Subd. 20d. **Skilled treatment services.** "Skilled treatment services" has the meaning provided in section 254B.01, subdivision 10.

245G.07 TREATMENT SERVICE.

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner;

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

(8) peer recovery support services must be provided by a recovery peer qualified according to section 245I.04, subdivision 18. Peer recovery support services must be provided according to sections 254B.05, subdivision 5, and 254B.052.

254B.01 DEFINITIONS.

Subd. 5. **Local agency.** "Local agency" means the agency designated by a board of county commissioners, a local social services agency, or a human services board authorized under section 254B.03, subdivision 1, to determine financial eligibility for the behavioral health fund.

254B.04 ELIGIBILITY FOR BEHAVIORAL HEALTH FUND SERVICES.

Subd. 2a. **Eligibility for room and board services for persons in outpatient substance use disorder treatment.** A person eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), must score at level 4 on assessment dimensions related to readiness to change, relapse, continued use, or recovery environment in order to be assigned to services with a room and board component reimbursed under this section. Whether a treatment facility has been designated an institution for mental diseases under United States Code, title 42, section 1396d, shall not be a factor in making placements.

254B.181 SOBER HOMES.

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

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

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

(3) have written policies regarding evictions;

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

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

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

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

(8) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the United States Food and Drug Administration for the treatment of opioid use disorder;

(9) permit residents to use, as directed by a licensed prescriber, legally prescribed and dispensed or administered pharmacotherapies approved by the United States Food and Drug Administration to treat co-occurring substance use disorders and mental health conditions;

(10) have a fee schedule and refund policy;

(11) have rules for residents;

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

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

(14) distribute the sober home bill of rights.

Subd. 2. **Bill of rights.** An individual living in a sober home has the right to:

(1) have access to an environment that supports recovery;

(2) have access to an environment that is safe and free from alcohol and other illicit drugs or substances;

(3) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act, sections 626.557 to 626.5572;

(4) be treated with dignity and respect and to have personal property treated with respect;

(5) have personal, financial, and medical information kept private and to be advised of the sober home's policies and procedures regarding disclosure of such information;

(6) access, while living in the residence, to other community-based support services as needed;

(7) be referred to appropriate services upon leaving the residence, if necessary;

(8) retain personal property that does not jeopardize safety or health;

(9) assert these rights personally or have them asserted by the individual's representative or by anyone on behalf of the individual without retaliation;

(10) be provided with the name, address, and telephone number of the ombudsman for mental health, substance use disorder, and developmental disabilities and information about the right to file a complaint;

(11) be fully informed of these rights and responsibilities, as well as program policies and procedures; and

(12) not be required to perform services for the residence that are not included in the usual expectations for all residents.

Subd. 3. **Complaints; ombudsman for mental health and developmental disabilities.** Any complaints about a sober home may be made to and reviewed or investigated by the ombudsman for mental health and developmental disabilities, pursuant to sections 245.91 and 245.94.

Subd. 4. **Private right of action.** In addition to pursuing other remedies, an individual may bring an action to recover damages caused by a violation of this section.

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.

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.

Laws 2021, First Special Session chapter 7, article 13, section 75, as amended Subdivisions 3, 3as amended by Laws 2024, chapter 108, article 1, section 28; 6, 6as amended by Laws 2024, chapter 108, article 1, section 28;

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

Sec. 28. Laws 2021, First Special Session chapter 7, article 13, section 75, is amended to read:

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

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

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

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

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

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

(1) people with disabilities who use waiver services;

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

(3) disability and behavioral health advocates;

(4) lead agency representatives; and

(5) waiver service providers.

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

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

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

Subd. 4. **Required report.** Prior to seeking federal approval for any aspect of waiver reimagine phase II and in ~~consultation~~ collaboration with the Waiver Reimagine Advisory Committee, the

commissioner must submit to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services a report on plans for waiver reimagine phase II. The report must also include any plans to adjust or modify the streamlined menu of services ~~or~~, the existing rate exemption criteria or process, the proposed individual budget ranges, and the role of MnCHOICES 2.0 assessment tool in determining service needs and individual budget ranges.

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

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

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

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

Sec. 28. Laws 2021, First Special Session chapter 7, article 13, section 75, is amended to read:

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

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

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

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

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

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

(1) people with disabilities who use waiver services;

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

(3) disability and behavioral health advocates;

(4) lead agency representatives; and

(5) waiver service providers.

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

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

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

Subd. 4. **Required report.** Prior to seeking federal approval for any aspect of waiver reimagine phase II and in ~~consultation~~ collaboration with the Waiver Reimagine Advisory Committee, the commissioner must submit to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services a report on plans for waiver reimagine phase II. The report must also include any plans to adjust or modify the streamlined menu of services ~~or~~, the existing rate exemption criteria or process, the proposed individual budget ranges, and the role of MnCHOICES 2.0 assessment tool in determining service needs and individual budget ranges.

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

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

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

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