ARTICLE 2

DISABILITY SERVICES

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

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

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

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

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

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

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

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

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

(1) nursing facility services under chapter 256R;

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

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

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

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

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(1) nursing facility services under chapter 256R;

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

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

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

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

House Language H2434-3

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The assessment used to establish medical assistance payment for long-term care services provided under chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face

Senate Language UEH2434-1

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The assessment used to establish medical assistance payment for long-term care services provided under chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face

assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

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

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

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

(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 daily 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; or

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

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

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

assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

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

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

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

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

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

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

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

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

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

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

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

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Sec. 4. 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The state must make financial contributions to the Minnesota Caregiver Retirement Fund Trust pursuant to a collective bargaining agreement negotiated under this section. The financial contributions by the state must be held in trust for the purpose of paying, from principal, income, or both, the costs associated with creating, implementing, and

administering a defined contribution or other individual account retirement program for individual providers of direct support services working under a collective bargaining agreement and providing services through a covered program under section 256B.0711. A board of trustees composed of an equal number of trustees appointed by the governor and trustees appointed by the exclusive representative under this section must administer, manage, and otherwise jointly control the Minnesota Caregiver Retirement Fund Trust. The trust must not be an agent of either the state or the exclusive representative.

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

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

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

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

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

administering a defined contribution or other individual account retirement program for individual providers of direct support services working under a collective bargaining agreement and providing services through a covered program under section 256B.0711. A board of trustees composed of an equal number of trustees appointed by the governor and trustees appointed by the exclusive representative under this section must administer, manage, and otherwise jointly control the Minnesota Caregiver Retirement Fund Trust. The trust must not be an agent of either the state or the exclusive representative.

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

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

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

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

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

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

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

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

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

(b) If the commissioner has issued more than one license to the license holder under this chapter, the ~~conditions imposed~~ order issued under this section shall be specific to the license

for the program at which the violations of applicable law or rules occurred and shall not apply to other licenses held by the same license holder if those programs are being operated in substantial compliance with applicable law and rules.

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

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

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

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

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

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

(2) explain why they are in error; and

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

Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration. A request for reconsideration does not stay any provisions

or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

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

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

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

Sec. 5. **[245A.142] EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION PROVISIONAL LICENSURE.**

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

Subd. 2. **Provisional license.** (a) Beginning on January 1, 2026, the commissioner shall begin issuing provisional licenses to enrolled EIDBI agencies while permanent licensing standards are developed and shall not enroll new EIDBI agencies to provide EIDBI services. EIDBI agencies enrolled by December 31, 2025, have until June 1, 2026, to submit an application for provisional licensure on the forms and in the manner prescribed by the commissioner.

(b) Beginning June 2, 2026, an EIDBI agency shall not operate if it has not submitted an application for provisional licensure under this section. Failure to submit an application for provisional licensure by June 2, 2026, will result in disenrollment from providing EIDBI services.

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

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

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

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

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

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

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

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

(1) 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 limited to the provisions of this section;

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

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

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

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

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

(5) comply with section 256B.0949, subdivisions 2, 3a, 6, 7, 14, 15, 16, and 16a, and exceptions to qualifications, standards, and requirements granted by the commissioner under section 256B.0949, subdivision 17.

Subd. 5. **Reporting of maltreatment.** An EIDBI agency must comply with the requirements of reporting maltreatment of vulnerable adults and minors under sections 245A.65, 245A.66, and 626.557 and chapter 260E.

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

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

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

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

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

(2) investigate reports of maltreatment;

(3) investigate complaints against agencies;

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

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

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

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

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

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

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

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

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

Subd. 6. **Background studies.** An EIDBI agency must initiate a background study through the commissioner's NETStudy 2.0 system as provided under chapter 245C.

Subd. 7. **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. 8. **Disenrollment.** The commissioner shall disenroll an agency from providing EIDBI services under chapter 256B if:

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

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

Subd. 9. **Transition to nonprovisional EIDBI license; future licensure standards.** (a) The commissioner must develop a process and transition plan for comprehensive EIDBI agency licensure by July 1, 2027.

(b) By January 1, 2028, the commissioner shall establish standards for nonprovisional EIDBI agency licensure and submit proposed legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over human services licensing.

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

Sec. 6. 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;

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

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

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

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

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

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

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

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

(1) the recency of the disqualifying characteristic;

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

(3) the number of disqualifying characteristics;

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2024, section 245D.091, subdivision 2, is amended to read:

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

(1) ethical considerations;

(2) functional assessment;

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

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

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

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

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

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

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

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

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

(1) ethical considerations;

(2) functional assessment;

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(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

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

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

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

(11) demonstrated expertise with populations being served; and

(12) must be a:

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

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

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

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

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

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

(vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited

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(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

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

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

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

(11) demonstrated expertise with populations being served; and

(12) must be a:

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

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

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

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

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

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

(vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited

college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services; or

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

Sec. 8. Minnesota Statutes 2024, section 245D.091, subdivision 3, is amended to read:

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

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

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

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

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

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

(1) 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;

(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

college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. **[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

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

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

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

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

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

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

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

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

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

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

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

(2) a child's case manager conducts and documents an assessment of the residential setting and its environment before services are provided and at least once each calendar year thereafter if services continue to be provided at that residence. The assessment must

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.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Support grants; criteria and limitations.** (a) A county board may choose to participate in the consumer support grant program. If a county has not chosen to participate by July 1, 2002, the commissioner shall contract with another county or other entity to provide access to residents of the nonparticipating county who choose the consumer support grant option. The commissioner shall notify the county board in a county that has declined to participate of the commissioner's intent to enter into a contract with another county or other entity at least 30 days in advance of entering into the contract. The local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum

amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 11.

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

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

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

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

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

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

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

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

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

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

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

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Sec. 10. **[256.4768] DISABILITY SERVICES TECHNOLOGY AND ADVOCACY EXPANSION GRANT.**

Subdivision 1. **Establishment.** (a) A disability services technology and advocacy expansion grant is established to:

(1) support the expansion of assistive technology and remote support services for people with disabilities; and

(2) strengthen advocacy efforts for individuals with disabilities and the providers who serve individuals with disabilities.

(b) The commissioner of human services must award the grant to an eligible grantee.

Subd. 2. **Eligible grantee.** An eligible grantee must:

(1) be a nonprofit organization with a statewide reach;

(2) have demonstrated knowledge of various forms of assistive technology and remote support for people with disabilities; and

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(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. 75. **DISABILITY SERVICES TECHNOLOGY AND ADVOCACY EXPANSION GRANT.**

Subdivision 1. **Establishment.** (a) A disability services technology and advocacy expansion grant is established to:

(1) support the expansion of assistive technology and remote support services for people with disabilities; and

(2) strengthen advocacy efforts for individuals with disabilities and the providers who serve individuals with disabilities.

(b) The commissioner of human services must award the grant to an eligible grantee. In awarding the grant, the commissioner must consult with the commissioner of administration's System of Technology to Achieve Results (STAR) Program under Minnesota Statutes, section 16B.055.

Subd. 2. **Eligible grantee.** An eligible grantee must:

(1) be a nonprofit organization with a statewide reach;

(2) have demonstrated knowledge of various forms of assistive technology and remote support for people with disabilities; and

(3) have proven capacity to provide education and training to multiple constituencies.

Subd. 3. **Allowable uses of grant money.** Grant money must be used to:

(1) develop and deliver comprehensive training programs for lead agencies, disability service providers, schools, employment support agencies, and individuals with disabilities and their families to ensure effective use of assistive technology and remote support tools. Training must address specific challenges faced by individuals with disabilities, such as accessibility, independence, and health monitoring;

(2) provide resources and support to advocacy organizations that work with individuals with disabilities and service providers. Resources and support must be used to promote the use of assistive technology to increase self-determination and community participation;

(3) maintain, distribute, and create accessible resources related to assistive technology and remote support. Materials must be tailored to address the unique needs of individuals with disabilities and the people and organizations who support individuals with disabilities;

(4) conduct research to explore new and emerging assistive technology solutions that address the evolving needs of individuals with disabilities. The research must emphasize the role of technology in promoting independence, improving quality of life, and ensuring safety; and

(5) conduct outreach initiatives to engage disability communities, service providers, and advocacy groups across Minnesota to promote awareness of assistive technology and remote support services. Outreach initiatives must focus on reaching underserved and rural populations.

Subd. 4. **Grant period.** The grant period under this section is from July 1, 2025, to June 30, 2030.

Subd. 5. **Evaluation and reporting requirements.** (a) The grant recipient must submit an annual report by June 30 each year to the legislative committees with jurisdiction over disability services. The annual report must include:

(1) the number of individuals with disabilities and service providers who received training during the reporting year;

(2) data on the impact of assistive technology and remote support in improving quality of life, safety, and independence for individuals with disabilities; and

(3) have proven capacity to provide education and training to multiple constituencies.

Subd. 3. **Allowable uses of grant money.** Grant money must be used to:

(1) develop and deliver comprehensive training programs for lead agencies, disability service providers, schools, employment support agencies, and individuals with disabilities and their families to ensure effective use of assistive technology and remote support tools. Training programs must be developed in consultation with the STAR Program to ensure alignment with national assistive technology standards and best practices. Training must address specific challenges faced by individuals with disabilities, such as accessibility, independence, and health monitoring;

(2) provide resources and support to advocacy organizations that work with individuals with disabilities and service providers. Resources and support must be used to promote the use of assistive technology to increase self-determination and community participation;

(3) maintain, distribute, and create accessible resources related to assistive technology and remote support. Resources must be developed in collaboration with the STAR Program to reflect current assistive technology tools and guidance that are tailored to Minnesota's disability community. Materials must be tailored to address the unique needs of individuals with disabilities and the people and organizations who support individuals with disabilities;

(4) conduct research to explore new and emerging assistive technology solutions that address the evolving needs of individuals with disabilities. The research must emphasize the role of technology in promoting independence, improving quality of life, and ensuring safety; and

(5) conduct outreach initiatives to engage disability communities, service providers, and advocacy groups across Minnesota to promote awareness of assistive technology and remote support services. Outreach initiatives must focus on reaching underserved and rural populations.

Subd. 5. **Grant period.** The grant period under this section is from July 1, 2025, to June 30, 2030.

Subd. 4. **Evaluation and reporting requirements.** (a) The grant recipient must submit an annual report by June 30 each year to the chairs and ranking minority members of the legislative committees with jurisdiction over disability services. The annual report must include:

(1) the number of individuals with disabilities and service providers who received training during the reporting year;

(2) data on the impact of assistive technology and remote support in improving quality of life, safety, and independence for individuals with disabilities; and

(3) recommendations for further advancing technology-driven disability advocacy efforts based on feedback and research findings.

(b) No later than three months after the grant period has ended, a final evaluation must be submitted to the legislative committees with jurisdiction over disability services to assess the overall impact on expanding access to assistive technology and remote support, with a focus on lessons learned and future opportunities for Minnesota's disability communities and service providers.

(3) recommendations for further advancing technology-driven disability advocacy efforts based on feedback and research findings.

(b) No later than three months after the grant period has ended, a final evaluation must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over disability services to assess the overall impact on expanding access to assistive technology and remote support, with a focus on lessons learned and future opportunities for Minnesota's disability communities and service providers.

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

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

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

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

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

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

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

(c) The commissioner shall conduct revalidation as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) serves primarily a pediatric population.

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

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

(l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a

federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

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

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

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

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

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

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

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

~~(b)~~ (c) A personal care assistance provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 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:

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

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

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

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

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

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

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

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

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

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

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

Sec. 22. Minnesota Statutes 2024, section 256B.0911, subdivision 13, is amended to read:

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

(b) MnCHOICES certified assessors must have received training and certification specific to assessment and consultation for long-term care services in the state and either:

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

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

(3) be a registered nurse~~; and~~.

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

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

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

Sec. 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

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

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

(3) be a registered nurse~~; and~~.

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

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

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

Sec. 23. Minnesota Statutes 2024, section 256B.0911, subdivision 14, is amended to read:

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

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

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

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

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

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

responsible for oversight, compliance, and quality assurance for all assessments performed under the contract.

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.

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

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

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

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

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

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

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

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

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

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

Sec. 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 22 to 64 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; and 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

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

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

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

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

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

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

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

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

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

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

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

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, upon denial of attestation to 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 26, is amended to read:

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

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

(c) Effective January 1, 2026, or upon federal approval, whichever is later, the determination of need for nursing facility level of care must be made based on criteria in

provides informed choice and the person being reassessed or the person's legal representative provides informed consent. Lead agencies must document that informed choice was offered.

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

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

(d) The assessment conducted under this section must:

(1) verify current assessed support needs;

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

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

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

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

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

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

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

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

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

(c) Effective January 1, 2026, or upon federal approval, whichever is later, the determination of need for nursing facility level of care must be made based on criteria in

section 144.0724, subdivision 11, except for determinations of need for purposes of the brain injury and community access for disability inclusion waivers under section 256B.49. Determinations of need for the brain injury and community access for disability inclusion waivers must be made based on criteria in section 144.0724, subdivision 11a.

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

Sec. 21. 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;

section 144.0724, subdivision 11, except for determinations of need for purposes of the brain injury and community access for disability inclusion waivers under section 256B.49.

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

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

(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. 22. 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

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

Subd. 35. **Dashboard on assessment completions.** (a) The commissioner shall maintain a dashboard on the department's public website containing summary data on the completion of assessments under this section. The commissioner must update the dashboard at least twice per year.

(b) The dashboard must include:

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

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

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

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

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

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 2024, section 256B.0924, subdivision 6, is amended to read:

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

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

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

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

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

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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.

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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.

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(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.

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

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

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

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

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

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

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

(1) is severe and chronic;

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

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

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

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(n)~~ (o) "Legal representative" means the parent of a child who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about service for a person. For the purpose of this subdivision, "other representative with

legal authority to make decisions" includes a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

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

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

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

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

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

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

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

(1) applied behavior analysis (ABA);

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

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

~~(4) PLAY project;~~

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

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

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

certification overseeing implementation, must document the required qualifications to meet fidelity to the specific model in a manner determined by the commissioner.

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

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

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

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

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

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

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

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

(i) Family caregiver training and counseling is specialized training and education for a family or primary caregiver to understand the person's developmental status and help with

Sec. 24. Minnesota Statutes 2024, section 256B.0949, subdivision 15, is amended to read:

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

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

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

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

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

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

the person's needs and development. This service must be provided by the QSP, level I provider, or level II provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

(2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 25. 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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 35. Minnesota Statutes 2024, section 256B.0949, subdivision 16a, is amended to read:

Subd. 16a. **Background studies.** An early intensive developmental and behavioral intervention services agency must fulfill any background studies requirements under this

section by initiating a background study through the commissioner's NETStudy 2.0 system as provided under sections 245C.03, subdivision 15~~, and 245C.10, subdivision 17~~. Before an individual subject to the background study requirements under this subdivision has direct contact with the person, the agency must have received a notice from the commissioner that the subject of the background study is:

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

(2) disqualified but the subject of the study has received a set-aside of the disqualification under section 245C.22.

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

Sec. 26. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision to read:

Subd. 18. **Provisional licensure.** Beginning on January 1, 2026, the commissioner shall begin issuing provisional licenses to enrolled EIDBI agencies pursuant to section 245A.142.

Sec. 36. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision to read:

Subd. 18. **Site visits and sanctions.** (a) The commissioner may conduct unannounced on-site inspections of any and all EIDBI agencies and service locations to verify that information submitted to the commissioner is accurate, determine compliance with all enrollment requirements, investigate reports of maltreatment, determine compliance with service delivery and billing requirements, and determine compliance with any other applicable laws or rules.

(b) The commissioner may withhold payment from an agency or suspend or terminate the agency's enrollment number if the agency fails to provide access to the agency's service locations or records or the commissioner determines the agency has failed to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

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

Sec. 27. Minnesota Statutes 2024, section 256B.19, subdivision 1, is amended to read:

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

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

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

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

(4) beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G~~.~~; and

(5) beginning July 1, 2026, or upon federal approval, whichever is later, 67 percent state funds and 33 percent county funds for the costs of services for all individual waiver recipients who receive rates determined under section 256B.4914, subdivision 14.

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

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

Sec. 37. Minnesota Statutes 2024, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined ~~likely~~ to require the level of care provided in a nursing facility as determined under section 256B.0911, subdivision 26, or a hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 38. Minnesota Statutes 2024, section 256B.49, subdivision 13, is amended to read:

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

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

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

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

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

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

(iii) employment service providers;

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

(v) providers of financial management services;

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

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

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

(1) finalizing the person-centered support plan;

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

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

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred

language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 10.

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

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

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

Sec. 28. 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;

Sec. 39. Minnesota Statutes 2024, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) life sharing;

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

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

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

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

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

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

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

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

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

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

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

Sec. 29. 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. 30. 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);

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

Sec. 40. Minnesota Statutes 2024, section 256B.4914, subdivision 5, is amended to read:

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

(b) The commissioner shall update the base wage index in subdivision 5a, publish these updated values, and load them into the rate management system ~~as follows:~~ on January 1, 2030, and every two years thereafter, based on wage data by SOC from the Bureau of Labor Statistics published in the spring approximately 21 months prior to the scheduled update.

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

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

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

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

Sec. 41. Minnesota Statutes 2024, section 256B.4914, subdivision 5a, is amended to read:

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

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

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

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(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);

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(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. 31. 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;~~

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

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

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

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

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

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

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

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

Sec. 42. Minnesota Statutes 2024, section 256B.4914, subdivision 5b, is amended to read:

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

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

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

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

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 6a, is amended to read:

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

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent; and

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

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

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

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

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

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

(b) The commissioner shall update the base wage index under subdivision 5a for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower, publish these updated values, and load them into the rate management system on January 1, 2026, and January 1, 2028, by the percentage change in the CPI-U from the date of the previous update to the data available 24 months and one day prior to the scheduled update. This paragraph expires December 31, 2029.

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

Sec. 43. Minnesota Statutes 2024, section 256B.4914, subdivision 6a, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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. 33. Minnesota Statutes 2024, section 256B.4914, subdivision 6b, is amended to read:

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

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) general administrative support ratio: 3.3 percent; and

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

~~(7) absence factor: 1.7 percent.~~

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

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

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

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

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

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

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

Sec. 44. Minnesota Statutes 2024, section 256B.4914, subdivision 6b, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) general administrative support ratio: 3.3 percent;

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

(7) absence factor: 1.7 percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective 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 6c, is amended to read:

Subd. 6c. **Integrated community supports; component values and calculation of payment rates.** (a) Component values for integrated community supports are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

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

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

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

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

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

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

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

Sec. 45. Minnesota Statutes 2024, section 256B.4914, subdivision 6c, is amended to read:

Subd. 6c. **Integrated community supports; component values and calculation of payment rates.** (a) Component values for integrated community supports are:

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

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

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

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

(5) general administrative support ratio: 13.25 percent; and

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

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

(b) Payments for integrated community supports must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs. The base shared direct staffing hours must be eight hours divided by the number of people receiving support in the integrated community support setting, and the individual direct staffing hours must be the average number of direct support hours provided directly to the service recipient;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours in clause (1) by the appropriate staff wages;

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

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

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

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(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

(b) Payments for integrated community supports must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs. The base shared direct staffing hours must be eight hours divided by the number of people receiving support in the integrated community support setting, and the individual direct staffing hours must be the average number of direct support hours provided directly to the service recipient;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours in clause (1) by the appropriate staff wages;

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

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

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

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

(10) add the results of clauses (8) and (9);

(11) add the standard general administrative support ratio~~,~~ and the program-related expense ratio~~, and the absence and utilization factor ratio~~;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective 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.

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

(10) add the results of clauses (8) and (9);

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

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 46. Minnesota Statutes 2024, section 256B.4914, subdivision 7a, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. The amendments to paragraph (a), clause (1), are effective the day following final enactment.

Sec. 47. Minnesota Statutes 2024, section 256B.4914, subdivision 7b, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. The amendments to paragraph (a), clause (1), are effective the day following final enactment.

Sec. 48. Minnesota Statutes 2024, section 256B.4914, subdivision 7c, is amended to read:

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

(1) competitive workforce factor: ~~6.7 percent.~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

Sec. 35. 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;

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

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

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

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

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

(12) this is the subtotal rate;

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

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

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

EFFECTIVE DATE. The amendments to paragraph (a), clause (1), are effective the day following final enactment.

Sec. 49. Minnesota Statutes 2024, section 256B.4914, subdivision 8, is amended to read:

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

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

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(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;

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

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

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

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

(5) program plan support ratio: 15.5 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

(14) for services provided in a shared manner, divide the total payment in clause (13) as follows:

(i) for employment exploration services, divide by the number of service recipients, not to exceed five;

(ii) for employment support services, divide by the number of service recipients, not to exceed six;

(iii) for individualized home supports with training and individualized home supports with family training, divide by the number of service recipients, not to exceed three; and

(iv) for night supervision, divide by the number of service recipients, not to exceed two; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(e) Effective January 1, 2027, or upon federal approval, whichever is later, providers may not bill more than eight hours per day for individualized home supports with training and individualized home supports with family training. This maximum does not limit a person's use of other disability waiver services.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 36. 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

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for services provided in a shared manner, divide the total payment in clause (13) as follows:

(i) for employment exploration services, divide by the number of service recipients, not to exceed five;

(ii) for employment support services, divide by the number of service recipients, not to exceed six;

(iii) for individualized home supports with training and individualized home supports with family training, divide by the number of service recipients, not to exceed three; and

(iv) for night supervision, divide by the number of service recipients, not to exceed two; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(e) Effective January 1, 2026, or upon federal approval, whichever is later, providers must not bill more than nine hours per day for individualized home supports with training and individualized home supports with family training. This maximum does not limit a person's use of other disability waiver services.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 50. Minnesota Statutes 2024, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Unit-based services without programming; component values and calculation of payment rates.** (a) For the purposes of this section, unit-based services without programming include individualized home supports without training and night supervision provided to an individual outside of any service plan for a day program or residential support service. Unit-based services without programming do not include respite. This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, for the purposes of this section, unit-based services without programming include individualized

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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);

Senate Language UEH2434-1

home supports without training, awake night supervision, and asleep night supervision provided to an individual outside of any service plan for a day program or residential support service.

~~(b)~~ (c) Component values for unit-based services without programming are:

(1) competitive workforce factor: ~~6.7 percent;~~

(i) 6.7 percent. This item expires upon the effective date of item (ii);

(ii) effective January 1, 2026, or upon federal approval, whichever is later, 9.71 percent. This item expires upon the effective date of item (iii);

(iii) effective January 1, 2028, or upon federal approval, whichever is later, 21.79 percent. This item expires upon the effective date of item (iv); and

(iv) effective January 1, 2030, or upon federal approval, whichever is later, 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(c)~~ (d) A unit of service for unit-based services without programming is 15 minutes.

~~(d)~~ (e) Payments for unit-based services without programming must be calculated as follows unless the services are reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 to 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for individualized home supports without training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 37. 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) For rate exceptions related to behavioral needs, the lead agency must include:

(1) a documented behavioral diagnosis; or

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for individualized home supports without training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 51. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 14a. **Limitations on rate exceptions for residential services.** (a) Effective July 1, 2026, the commissioner must implement limitations on the size and number of rate exceptions for community residential services, customized living services, family residential services, and integrated community supports.

(b) The commissioner must restrict rate exceptions to the absence and utilization factor ratio to people temporarily receiving hospital or crisis respite services.

(c) For rate exceptions related to behavioral needs, the commissioner must include:

(1) a documented behavioral diagnosis; or

(2) determined assessed needs for behavioral supports as identified in the person's most recent assessment or reassessment under section 256B.0911.

(c) Community residential services rate exceptions must not include positive supports costs.

(d) The commissioner must not approve rate exception requests related to increased community time or transportation.

(e) 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.

(f) 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.

(g) The commissioner must publish online an annual report detailing the impact of the limitations under this subdivision on home and community-based services spending, including but not limited to:

(1) the number and percentage of rate exceptions granted and denied;

(2) total spending on community residential setting services and rate exceptions;

(3) trends in the percentage of spending attributable to rate exceptions; and

(4) an evaluation of the effectiveness of the limitations in controlling spending growth.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 38. 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.

(2) determined assessed needs for behavioral supports as identified in the person's most recent assessment.

(d) Community residential services rate exceptions must not include positive supports costs.

(e) The commissioner must not approve rate exception requests related to increased community time or transportation.

(f) For the commissioner to approve a rate exception annual renewal, the person's most recent assessment must indicate continued extraordinary needs in the areas cited in the exception request. If a person's assessment continues to identify these extraordinary needs, lead agencies requesting an annual renewal of rate exceptions must submit provider-created documentation supporting the continuation of the exception, including but not limited to:

(1) payroll records for direct care wages cited in the request;

(2) payment records or receipts for other costs cited in the request; and

(3) documentation of expenses paid that were identified as necessary for the initial rate exception.

(g) The commissioner must not increase rate exception annual renewals that request an exception to direct care or supervision wages more than the most recently implemented base wage index determined under subdivision 5.

(h) The commissioner must publish online an annual report detailing the impact of the limitations under this subdivision on home and community-based services spending, including but not limited to:

(1) the number and percentage of rate exceptions granted and denied;

(2) total spending on community residential setting services and rate exceptions;

(3) trends in the percentage of spending attributable to rate exceptions; and

(4) an evaluation of the effectiveness of the limitations in controlling spending growth.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 52. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 20. **Sanctions and monetary recovery.** Payments under this section are subject to the sanctions and monetary recovery requirements under section 256B.064.

Sec. 53. Minnesota Statutes 2024, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section and section 256B.851, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means:

(1) dressing, including assistance with choosing, applying, and changing clothing and applying special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Grooming includes nail care, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and applying orthotics required for eating or feeding;

(5) transfers, including assistance with transferring the participant from one seating or reclining area to another;

(6) mobility, including assistance with ambulation and use of a wheelchair. Mobility does not include providing transportation for a participant;

(7) positioning, including assistance with positioning or turning a participant for necessary care and comfort; and

(8) toileting, including assistance with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, advanced practice registered nurse, or physician's assistant and is specified in an assessment summary, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician, advanced practice registered nurse, or physician's assistant and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the support plan identified in sections 256B.092, subdivision 1b, and 256S.10.

(i) "Consultation services" means ~~a Minnesota health care program enrolled provider organization that provides assistance to the~~ assisting a participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child must not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants. Extended CFSS excludes the purchase of goods.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community, including traveling to medical appointments. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the individual CFSS service delivery plan.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 10.

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression toward self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker must not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one.

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into a written agreement to receive services at the same time, in the same setting, and through the same agency-provider or FMS provider.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

(bb) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 54. Minnesota Statutes 2024, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivisions 17 to 21, 23, 24, and 29 to 31;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when the participant experiences a change in condition or needs a change in the services or supports; and

(3) be completed using the format established by the commissioner.

(b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's assessor as defined in section 256B.0911 to the participant or the participant's representative and chosen CFSS providers within ten business days and must include the participant's right to appeal the assessment under section 256.045, subdivision 3.

~~(c) The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in this subdivision. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in this subdivision and participants must use consultation services to complete their orientation and selection of a service model.~~

Sec. 55. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

Subd. 5a. **Temporary authorization without assessment.** The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model. The lead agency assessor may authorize a temporary authorization for CFSS services to be provided under the agency-provider model without using the assessment process described in subdivision 5. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this subdivision shall have no bearing on a future authorization. For CFSS services needed beyond the 45-day temporary authorization, the lead agency must conduct an assessment as described in subdivision 5 and participants must use consultation services to complete their orientation and selection of a service model.

Sec. 56. Minnesota Statutes 2024, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

Sec. 39. 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).

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(ii) increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) swimming lessons for a participant younger than 12 years of age whose disability puts the participant at a higher risk of drowning according to the Centers for Disease Control Vital Statistics System;

~~(6)~~ (7) services described under subdivision 17 provided by a consultation services provider ~~as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider~~ meeting the requirements of subdivision 17a;

~~(7)~~ (8) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

~~(8)~~ (9) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. Covered services under this clause are subject to the limitations described in subdivision 7b; and

~~(9)~~ (10) worker training and development services as described in subdivision 18a.

EFFECTIVE DATE. This section is effective July 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 57. Minnesota Statutes 2024, section 256B.85, subdivision 7a, is amended to read:

Subd. 7a. **Enhanced rate.** (a) An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). This paragraph expires upon the effective date of paragraph (c).

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~~(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. 40. 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:

Senate Language UEH2434-1

(c) Effective January 1, 2027, or upon federal approval, whichever is later, an enhanced rate of 112.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day.

~~(b)~~ (d) An agency provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the support workers, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums. The agency provider must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

~~(c)~~ (e) Any change in the eligibility criteria for the enhanced rate for CFSS as described in this subdivision and referenced in subdivision 16, paragraph (e), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 58. Minnesota Statutes 2024, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

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(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

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(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.

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses. This paragraph expires upon the effective date of paragraph (h).

(h) Effective January 1, 2026, or upon federal approval, whichever is later, the service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating and the payment methodologies under section 256B.851; and

(2) an adjustment needed for administrative expenses.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 59. Minnesota Statutes 2024, section 256B.85, subdivision 8a, is amended to read:

Subd. 8a. **Authorization; exceptions.** All CFSS services must be authorized by the commissioner or the commissioner's designee as described in subdivision 8 except when:

(1) the lead agency temporarily authorizes services in the agency-provider model as described in subdivision ~~5, paragraph (c)~~ 5a;

(2) CFSS services in the agency-provider model were required to treat an emergency medical condition that if not immediately treated could cause a participant serious physical or mental disability, continuation of severe pain, or death. The CFSS agency provider must request retroactive authorization from the lead agency no later than five working days after providing the initial emergency service. The CFSS agency provider must be able to substantiate the emergency through documentation such as reports, notes, and admission or discharge histories. A lead agency must follow the authorization process in subdivision 5 after the lead agency receives the request for authorization from the agency provider;

(3) the lead agency authorizes a temporary increase to the amount of services authorized in the agency or budget model to accommodate the participant's temporary higher need for services. Authorization for a temporary level of CFSS services is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this clause shall have no bearing on a future authorization;

(4) a participant's medical assistance eligibility has lapsed, is then retroactively reinstated, and an authorization for CFSS services is completed based on the date of a current assessment, eligibility, and request for authorization;

(5) a third-party payer for CFSS services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(6) the commissioner has determined that a lead agency or state human services agency has made an error; or

(7) a participant enrolled in managed care experiences a temporary disenrollment from a health plan, in which case the commissioner shall accept the current health plan authorization for CFSS services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

Sec. 60. Minnesota Statutes 2024, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services provided by support workers and staff providing worker training and development services who are employed by an agency-provider that meets the criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's CFSS service delivery plan. The agency must make a reasonable effort to fulfill the participant's request for the participant's preferred support worker.

(c) A participant may use authorized units of CFSS services as needed within a service agreement that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's CFSS service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits, except all of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by participants who are restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under ~~this~~ the agency-provider model, along with support worker services, must:

(1) specify the goods in the CFSS service delivery plan and detailed budget for expenditures that must be approved by the lead agency, case manager, or care coordinator; and

(2) use the FMS provider for the billing and payment of such goods.

(h) The agency provider is responsible for ensuring that any worker driving a participant under subdivision 2, paragraph (o), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

Sec. 61. Minnesota Statutes 2024, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants exercise responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use consultation services specified in subdivision 17 and services specified in subdivision 13a provided by an FMS provider. Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, family and medical benefit insurance, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7.

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) If two or more participants using the budget model live in the same household and have the same support worker, the participants must use the same FMS provider.

(d) If the FMS provider advises that there is a joint employer in the budget model, all participants associated with that joint employer must use the same FMS provider.

(e) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under, but not limited to, the following circumstances:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

Sec. 41. 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

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative is unable to fulfill the responsibilities under the budget model, as specified in subdivision 14.

(f) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph (e), clause (3), to disenroll or exclude the participant from the budget model.

Sec. 62. Minnesota Statutes 2024, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that the support worker:

(i) is not disqualified under section 245C.14; or

(ii) is disqualified, but has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. CFSS support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

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(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS qualify for an enhanced rate if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements. This paragraph expires upon the effective date of paragraph (f).

(f) Effective January 1, 2026, or upon federal approval, whichever is later, CFSS qualify for an enhanced rate or budget if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code

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(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS qualify for an enhanced rate or budget if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements. This paragraph expires December 31, 2026.

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.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 63. Minnesota Statutes 2024, section 256B.85, subdivision 17a, is amended to read:

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) ~~are~~ be under contract with the department and enrolled as a Minnesota health care program provider;

(3) ~~are not~~ not be the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the consultation service provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(6) employ lead professional staff with a minimum of two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(7) report maltreatment as required under chapter 260E and section 626.557;

(8) comply with medical assistance provider requirements;

(9) understand the CFSS program and its policies;

(10) ~~are~~ be knowledgeable about self-directed principles and the application of the person-centered planning process;

(11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

Sec. 42. 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;

(12) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Sec. 64. Minnesota Statutes 2024, section 256B.851, subdivision 5, is amended to read:

Subd. 5. **Payment rates; component values.** (a) The commissioner must use the following component values:

(1) employee vacation, sick, and training factor, 8.71 percent;

(2) employer taxes and workers' compensation factor, 11.56 percent;

(3) employee benefits factor, 12.04 percent;

(4) client programming and supports factor, 2.30 percent;

(5) program plan support factor, 7.00 percent;

(6) general business and administrative expenses factor, 13.25 percent;

(7) program administration expenses factor, 2.90 percent; and

(8) absence and utilization factor, 3.90 percent.

~~(b) For purposes of implementation, the commissioner shall use the following implementation components:~~

~~(1) personal care assistance services and CFSS: 88.19 percent;~~

~~(2) enhanced rate personal care assistance services and enhanced rate CFSS: 88.19 percent; and~~

~~(3) qualified professional services and CFSS worker training and development: 88.19 percent.~~

~~(c)~~ (b) Effective January 1, 2025, for purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 92.08 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 92.08 percent; and

(3) qualified professional services and CFSS worker training and development: 92.08 percent. This paragraph expires upon the effective date of subdivision 5a.

~~(d)~~ (c) The commissioner shall use the following worker retention components:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is zero percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 2.17 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.36 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 7.35 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 10.81 percent. This paragraph expires upon the effective date of subdivision 5b.

~~(c)~~ (d) The commissioner shall define the appropriate worker retention component based on the total number of units billed for services rendered by the individual provider since July 1, 2017. The worker retention component must be determined by the commissioner for each individual provider and is not subject to appeal.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 43. 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. 44. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5b. **Payment rates; worker retention components.** 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 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.

~~(c)~~ (d) The commissioner shall define the appropriate worker retention component under subdivision 5b or 5c based on the total number of units billed for services rendered by the individual provider since July 1, 2017. The worker retention component must be determined by the commissioner for each individual provider and is not subject to appeal.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 65. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5a. **Payment rates; implementation factor.** Effective January 1, 2026, or upon federal approval, whichever is later, for purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 92.20 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 92.20 percent; and

(3) qualified professional services and CFSS worker training and development: 92.20 percent.

Sec. 66. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5b. **Payment rates; worker retention component.** Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner shall use the following worker retention components:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is zero percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.05 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 6.24 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 9.23 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 12.69 percent.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 45. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5c. **Payment rates; enhanced worker retention components.** Effective January 1, 2027, or upon federal approval, whichever is later, for purposes of implementation, the commissioner shall use the following implementation components if a worker has completed either the orientation for individual providers offered through the Home Care Orientation Trust or an orientation defined and offered by the commissioner:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.88 percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 5.92 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 8.11 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 11.10 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 14.56 percent.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 46. 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:

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.05 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 6.24 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 9.23 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 12.69 percent.

Sec. 67. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 5c. **Payment rates; enhanced worker retention component.** Effective January 1, 2027, or upon federal approval, whichever is later, the commissioner shall use the following worker retention components if a worker has completed either the orientation for individual providers offered through the Home Care Orientation Trust or an orientation defined and offered by the commissioner:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.88 percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 5.92 percent;

(3) for workers who have provided between 2,001, and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 8.11 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 11.10 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 14.56 percent.

Sec. 68. Minnesota Statutes 2024, section 256B.851, subdivision 6, is amended to read:

Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine the rate for personal care assistance services, CFSS, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, enhanced rate CFSS, qualified professional services, and CFSS worker training and development as follows:

(1) multiply the appropriate total wage component value calculated in subdivision 4 by one plus the employee vacation, sick, and training factor in subdivision 5;

(2) for program plan support, multiply the result of clause (1) by one plus the program plan support factor in subdivision 5;

(3) for employee-related expenses, add the employer taxes and workers' compensation factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is employee-related expenses. Multiply the product of clause (2) by one plus the value for employee-related expenses;

(4) for client programming and supports, multiply the product of clause (3) by one plus the client programming and supports factor in subdivision 5;

(5) for administrative expenses, add the general business and administrative expenses factor in subdivision 5, the program administration expenses factor in subdivision 5, and the absence and utilization factor in subdivision 5;

(6) divide the result of clause (4) by one minus the result of clause (5). The quotient is the hourly rate;

(7) multiply the hourly rate by the appropriate implementation component under subdivision 5 or 5a. This is the adjusted hourly rate; and

(8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment rate.

(b) In processing personal care assistance provider agency and CFSS provider agency claims, the commissioner shall incorporate the 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 shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. 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.

(1) multiply the appropriate total wage component value calculated in subdivision 4 by one plus the employee vacation, sick, and training factor in subdivision 5;

(2) for program plan support, multiply the result of clause (1) by one plus the program plan support factor in subdivision 5;

(3) for employee-related expenses, add the employer taxes and workers' compensation factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is employee-related expenses. Multiply the product of clause (2) by one plus the value for employee-related expenses;

(4) for client programming and supports, multiply the product of clause (3) by one plus the client programming and supports factor in subdivision 5;

(5) for administrative expenses, add the general business and administrative expenses factor in subdivision 5, the program administration expenses factor in subdivision 5, and the absence and utilization factor in subdivision 5;

(6) divide the result of clause (4) by one minus the result of clause (5). The quotient is the hourly rate;

(7) multiply the hourly rate by the appropriate implementation component under subdivision 5 or 5a. This is the adjusted hourly rate; and

(8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment rate.

(b) In processing personal care assistance provider agency and CFSS provider agency claims, the commissioner shall incorporate the applicable worker retention ~~component~~ components specified in subdivision 5, 5b, or 5c, by multiplying one plus the total adjusted payment rate by the appropriate worker retention component under subdivision 5, ~~paragraph (d)~~ 5b, or 5c.

(c) The commissioner must publish the total final payment rates.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 69. Minnesota Statutes 2024, section 256B.851, subdivision 7, is amended to read:

Subd. 7. **Treatment of rate adjustments provided outside of cost components.** Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section, including but not limited to those implemented to enable participant-employers and provider agencies to meet the terms and conditions of any collective bargaining agreement negotiated under chapter 179A, shall be applied as changes to the value of component values ~~or~~, implementation components, or worker retention components in ~~subdivision~~ subdivisions 5 to 5c.

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. 48. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 7a. **Budget determinations.** The commissioner shall increase the authorized amount for the CFSS budget model of those CFSS participant-employers employing individual providers who have provided more than 1,000 hours of services as well as individual providers who have completed the orientation offered by the Home Care Orientation Trust or an orientation defined and offered by the commissioner. The commissioner shall determine the amount and method of the 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. 49. Minnesota Statutes 2024, section 260E.14, subdivision 1, is amended to read:

Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency responsible for investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D.

(c) The Department of Health is the agency responsible for screening and investigating allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under sections 245A.142 and 256B.0949.

Sec. 70. Minnesota Statutes 2024, section 256B.851, is amended by adding a subdivision to read:

Subd. 7a. **Budget determinations.** The commissioner shall increase the authorized amount for the CFSS budget model of those CFSS participant-employers employing individual providers who have provided more than 1,000 hours of services and individual providers who have completed the orientation offered by the Home Care Orientation Trust or an orientation defined and offered by the commissioner. The commissioner shall determine the amount and method of the authorized amount increase.

Sec. 71. Minnesota Statutes 2024, section 260E.14, subdivision 1, is amended to read:

Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency responsible for investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D.

(c) The Department of Health is the agency responsible for screening and investigating allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under sections 245A.142 and 256B.0949.

~~(c)~~ (f) A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

~~(f)~~ (g) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in facilities or programs not listed in paragraph (a) that are licensed or certified under chapters 142B and 142C.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 50. Minnesota Statutes 2024, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, family adult day services, mental health programs, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services, including EIDBI agencies under sections 245A.142 and 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 January 1, 2026.

Sec. 51. 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, 2028, 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.

~~(c)~~ (f) A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

~~(f)~~ (g) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in facilities or programs not listed in paragraph (a) that are licensed or certified under chapters 142B and 142C.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 72. Minnesota Statutes 2024, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including, but not limited to, reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 73. Laws 2021, First Special Session chapter 7, article 13, section 73, is amended to read:

Sec. 73. **WAIVER REIMAGINE PHASE II.**

(a) Effective January 1, 2027, or upon federal approval, whichever is later, the commissioner of human services must implement a two-home and community-based services waiver program structure, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(b) Effective January 1, 2028, or upon federal approval, whichever is later, the commissioner of human services must implement an individualized budget methodology, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(c) The commissioner must develop an individualized budget methodology exception to support access to self-directed home care nursing services. Lead agencies must submit budget exception requests to the commissioner in a manner identified by the commissioner. Eligibility for the budget exception in this paragraph is limited to persons meeting all of the following criteria in the person's most recent assessment:

(1) the person is assessed to need the level of care delivered in a hospital setting as evidenced by the submission of the Department of Human Services form 7096, primary medical provider's documentation of medical monitoring and treatment needs;

(2) the person is assessed to receive a support range budget of E or H; and

(3) the person does not receive community residential services, family residential services, integrated community supports services, or customized living services.

(d) Home care nursing services funded through the budget exception developed under paragraph (c) must be ordered by a physician, physician assistant, or advanced practice registered nurse. If the participant chooses home care nursing, the home care nursing services must be performed by a registered nurse or licensed practical nurse practicing within the registered nurse's or licensed practical nurse's scope of practice as defined under Minnesota Statutes, sections 148.171 to 148.285. If after a person's annual reassessment under Minnesota Statutes, section 256B.0911, any requirements of this paragraph or paragraph (c) are no longer met, the commissioner must terminate the budget exception.

~~(c)~~ (e) The commissioner of human services may seek all federal authority necessary to implement this section.

~~(d)~~ (f) The commissioner must ensure that the new waiver service menu and individual budgets allow people to live in their own home, family home, or any home and community-based setting of their choice. The commissioner must ensure, within available resources and subject to state and federal regulations and law, that waiver reimagine does not result in unintended service disruptions.

(g) No later than January 1, 2027, 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

(b) The commissioner of human services must implement an individualized budget methodology, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(c) The commissioner must develop an individualized budget methodology exception to support access to self-directed home care nursing services. Lead agencies must submit budget exception requests to the commissioner in a manner identified by the commissioner. Eligibility for the budget exception in this paragraph is limited to persons meeting all of the following criteria in the person's most recent assessment:

(1) the person is assessed to need the level of care delivered in a hospital setting as evidenced by the submission of the Department of Human Services form 7096, primary medical provider's documentation of medical monitoring and treatment needs;

(2) the person is assessed to receive a support range budget of E or H; and

(3) the person does not receive community residential services, family residential services, integrated community supports services, or customized living services.

(d) Home care nursing services funded through the budget exception developed under paragraph (c) must be ordered by a physician, physician assistant, or advanced practice registered nurse. If the participant chooses home care nursing, the home care nursing services must be performed by a registered nurse or licensed practical nurse practicing within the registered nurse's or licensed practical nurse's scope of practice as defined under Minnesota Statutes, sections 148.171 to 148.285. If after a person's annual reassessment under Minnesota Statutes, section 256B.0911, any requirements of this paragraph or paragraph (c) are no longer met, the commissioner must terminate the budget exception.

~~(c)~~ (e) The commissioner of human services may seek all federal authority necessary to implement this section.

~~(d)~~ (f) The commissioner must ensure that the new waiver service menu and individual budgets allow people to live in their own home, family home, or any home and community-based setting of their choice. The commissioner must ensure, within available resources and subject to state and federal regulations and law, that waiver reimagine does not result in unintended service disruptions.

Sec. 74. Laws 2021, First Special Session chapter 7, article 13, section 75, subdivision 6, as amended by Laws 2024, chapter 108, article 1, section 28, is amended to read:

Subd. 6. **Online support planning tool.** The commissioner must develop an online support planning and tracking tool for people using disability waiver services that allows access to the total budget available to the person, the services for which they are eligible, and the services they have chosen and used. The commissioner must explore operability

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 tool prior to the tool's implementation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 52. Laws 2021, First Special Session chapter 7, article 13, section 75, subdivision 4, as amended by Laws 2024, chapter 108, article 1, section 28, is amended to read:

Subd. 4. **Required report.** Prior to seeking federal approval for any aspect of waiver reimagine phase II and ~~in collaboration with the Waiver Reimagine Advisory Committee~~ no later than December 15, 2026, 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, as well as the actual Waiver Reimagine plan intended to be submitted for federal approval. The report must also include any plans to adjust or modify the streamlined menu of services, the existing rate or budget exemption criteria or process~~,~~; the proposed individual budget ~~ranges,~~ based on need and not location of services, including additional budget resources beyond the resources required to meet assessed need that may be necessary for the individual to live in the least restrictive environment; and the role of MnCHOICES 2.0 assessment tool in determining service needs and individual ~~budget ranges~~ budgets.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 53. Laws 2023, chapter 61, article 1, section 5, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective January 1, ~~2026~~ 2028, 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. Laws 2023, chapter 61, article 1, section 27, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective January 1, ~~2026~~ 2028, or upon federal approval, whichever is later, except that paragraph (b) is effective the day following final enactment. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

options that would facilitate real-time tracking of a person's remaining available budget throughout the service year. The online support planning tool must provide information in an accessible format to support the person's informed choice. The commissioner must seek input from people with disabilities about the online support planning tool prior to its implementation. The commissioner must implement the online support planning and tracking tool no later than January 1, 2027.

EFFECTIVE DATE. This section is effective the day following final enactment.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 55. Laws 2023, chapter 61, article 1, section 30, the effective date, is amended to read:

EFFECTIVE DATE. The amendment to clause (5), item (ii), the amendment to clause (14), and the amendment striking clause (18) are effective January 1, 2024, or upon federal approval, whichever is later. The amendment to clause (4) is effective January 1, ~~2026~~ 2028, 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 2023, chapter 61, article 1, section 32, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective January 1, ~~2026~~ 2028, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 57. Laws 2023, chapter 61, article 1, section 47, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective January 1, ~~2026~~ 2028, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 58. 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~~ 2027, 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. 59. Laws 2023, chapter 61, article 1, section 85, the effective date, is amended to read:

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2024, or upon federal approval, whichever is later, and paragraph (b) is effective January 1, ~~2026~~ 2028, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 60. **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. 61. **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;

Sec. 81. **POSITIVE SUPPORTS COMPETENCY PROGRAM.**

(a) The commissioner shall establish a positive supports competency program with the money appropriated for this purpose.

(b) When establishing the positive supports competency program, the commissioner must use a community-partner-driven process to:

(1) define the core activities associated with effective intervention services at the levels of positive support specialist, positive support analyst, and positive support professional;

(2) create tools providers may use to track whether their positive supports specialists, positive support analysts, and positive support professionals are competently performing the core activities associated with effective intervention services;

(3) align existing training systems funded through the Department of Human Services and develop free online modules for competency-based training to prepare positive support specialists, positive support analysts, and positive support professionals to provide effective intervention services;

(4) assist providers interested in utilizing a competency-based training model to create a career pathway for the positive support analysts and positive support specialists within their organizations by using experienced professionals;

(5) create written guidelines, stories, and examples for providers that will be placed on Department of Human Services websites promoting capacity building; and

(6) disseminate resources and guidance to providers interested in meeting competency-based qualifications for positive supports through existing regional networks of experts, including communities of practice, and develop new avenues for disseminating these resources and guidance, including through implementation of ECHO models.

(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 Minnesota Statutes, chapter 13D. The task force may meet by telephone or interactive technology consistent with Minnesota Statutes, 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 additional resources beyond the resources 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 Disability Act (ADA) 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 Minnesota Statutes, 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. **Expiration.** The task force expires upon submission of the task force's report.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 62. **BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must increase the consumer-directed community support budgets identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S; and the alternative care program under Minnesota Statutes, section 256B.0913, by 0.13 percent.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 63. **ENHANCED BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must increase the consumer-directed community supports budget 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. 76. **BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner of human services must increase the consumer-directed community support budgets identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S; and the alternative care program under Minnesota Statutes, section 256B.0913, by 0.13 percent.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 77. **ENHANCED BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner of human services must increase the consumer-directed community supports budget exception percentage identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S; and the alternative care program under Minnesota Statutes, section 256B.0913, from 7.5 to 12.5.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 78. **STIPEND PAYMENTS TO SEIU HEALTHCARE MINNESOTA & IOWA BARGAINING UNIT MEMBERS.**

(a) The commissioner of human services shall issue stipend payments to collective bargaining unit members as required by the labor agreement between the state of Minnesota and the Service Employees International Union (SEIU) Healthcare Minnesota & Iowa.

(b) The definitions in Minnesota Statutes, section 290.01, apply to this section.

(c) For the purposes of this section, "subtraction" has the meaning given in Minnesota Statutes, section 290.0132, subdivision 1, and the rules in that subdivision apply to this section.

(d) The amount of stipend payments received by SEIU Healthcare Minnesota & Iowa collective bargaining unit members under this section is a subtraction.

(e) The amount of stipend payments received by SEIU Healthcare Minnesota & Iowa collective bargaining unit members under this section is excluded from income as defined

in Minnesota Statutes, sections 290.0693, subdivision 1, paragraph (i), and 290A.03, subdivision 3.

(f) Notwithstanding any law to the contrary, stipend payments under this section must not be considered income, assets, or personal property for purposes of determining or recertifying eligibility for:

(1) child care assistance programs under Minnesota Statutes, chapter 142E;

(2) general assistance, Minnesota supplemental aid, and food support under Minnesota Statutes, chapter 256D;

(3) housing support under Minnesota Statutes, chapter 256I;

(4) the Minnesota family investment program under Minnesota Statutes, chapter 142G; and

(5) economic assistance programs under Minnesota Statutes, chapter 256P.

(g) The commissioner of human services must not consider stipend payments under this section as income or assets under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (a); 3; or 3c, or for persons with eligibility determined under Minnesota Statutes, section 256B.057, subdivision 3, 3a, or 3b.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 79. **DIRECTION TO COMMISSIONER; COST REPORTING IMPROVEMENT AND DIRECT CARE STAFF REVIEW.**

(a) The commissioner of human services must consult with interested parties and make recommendations to the legislature to clarify provider cost reporting obligations to promote more uniform and meaningful data collection under Minnesota Statutes, section 256B.4914. By February 15, 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance draft legislation required to implement the commissioner's recommendations.

(b) The commissioner of human services must consult with interested parties and, based on the results of the cost reporting completed for calendar year 2026, recommend what, if any, encumbrance of medical assistance reimbursement is appropriate to support direct care staff retention and the provision of quality services under Minnesota Statutes, section 256B.4914. By January 15, 2028, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance draft legislation required to implement the commissioner's recommendations.

Sec. 80. **COMMUNITY FIRST SERVICES AND SUPPORTS REIMBURSEMENT DURING ACUTE CARE HOSPITAL STAYS.**

(a) The commissioner of human services must seek to amend Minnesota's federally approved community first services and supports program, authorized under United States Code, title 42, sections 1915(i) and 1915(k), to reimburse for delivery of community first services and supports under Minnesota Statutes, sections 256B.85 and 256B.851, during an acute care stay in an acute care hospital setting that does not have the effect of isolating individuals receiving community first services and supports from the broader community of individuals not receiving community first services and supports, as permitted under Code of Federal Regulations, title 42, section 441.530.

(b) Reimbursed services must:

(1) be identified in an individual's person-centered support plan as required under Minnesota Statutes, section 256B.0911;

(2) be provided to meet the needs of the person that are not met through the provision of hospital services;

(3) not substitute services that the hospital is obligated to provide as required under state and federal law; and

(4) be designed to preserve the person's functional abilities during a hospital stay for acute care and to ensure smooth transitions between acute care settings and home and community-based settings.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 82. **DIRECTION TO COMMISSIONER; INTEGRATED COMMUNITY SUPPORTS CODIFICATION.**

(a) The commissioner of human services must develop draft language to codify in Minnesota Statutes the standards and requirements for integrated community supports as specified in the federally approved brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans.

(b) When developing and drafting the proposed legislative language, the commissioner must consult with interested parties, including the Association of Residential Resources in Minnesota, the Residential Providers Association of Minnesota, the Minnesota Association of County Social Service Administrators, and people with disabilities currently or potentially receiving integrated community supports. The commissioner must ensure that the interested parties with whom the commissioner consults represent a broad spectrum of active and potential providers and service recipients. The commissioner's consultation with interested

parties must be transparent and provide the opportunity for meaningful input from active and potential providers and service recipients.

(c) The commissioner must submit the draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2026.

Sec. 83. **DIRECTION TO COMMISSIONER; PROVISIONAL OR TRANSITIONAL APPROVAL OF INTEGRATED COMMUNITY SERVICES SETTINGS.**

(a) The commissioner of human services must develop draft language to improve the process for approving integrated community supports settings, including a process for issuing provisional or transitional licenses to allow applicants to obtain an initial approval to operate prior to securing control of the approved setting. This process must also allow applicants to change the approved setting during the application review period when needed to ensure an available setting.

(b) The commissioner must submit the draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2026.

Sec. 84. **DIRECTION TO COMMISSIONER; GUIDANCE TO COUNTIES.**

Upon receipt of approval from the Centers for Medicare and Medicaid Services, the commissioner of human services shall provide guidance to counties on the administration of the family support program under Minnesota Statutes, section 252.32; the consumer support program under Minnesota Statutes, section 256.476; disability waivers under Minnesota Statutes, sections 256B.092 and 256B.49; and the community first services and supports program under Minnesota Statutes, section 256B.85, to clarify that the cost of adaptive or one-on-one swimming lessons provided to a person younger than 12 years of age whose disability puts the person at a higher risk of drowning according to the Centers for Disease Control Vital Statistics System is an allowable use of money.

Sec. 85. **DIRECTION TO COMMISSIONER; SWIMMING LESSONS COVERED UNDER DISABILITY WAIVERS.**

The commissioner of human services shall include swimming lessons for a participant younger than 12 years of age whose disability puts the participant at a higher risk of drowning as a covered service under the disability waivers, including the consumer-directed community supports option, under Minnesota Statutes, sections 256B.092 and 256B.49.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 86. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DEVELOPMENT OF COMPREHENSIVE EIDBI LICENSE.**

(a) By October 1, 2025, the commissioner of human services must convene a working group consisting of staff from the Department of Human Services with policy and clinical expertise related to EIDBI services, and with expertise in licensing standards for other licensed programs and settings, particularly other programs serving children; staff from the Department of Children, Youth, and Families with expertise in the licensing standards for home child care and child care centers; the Early Intensive Developmental and Behavioral Advisory Council; families of individuals receiving EIDBI services; advocates for individuals receiving EIDBI services; and other community partners and interested parties.

(b) The working group must advise the commissioner as the commissioner develops comprehensive EIDBI licensing standards and a plan to transition EIDBI agencies from the provisional license established under Minnesota Statutes, section 245A.142, to a newly established comprehensive EIDBI license. The working group must provide the commissioner with advice on at least the following topics:

(1) basic health and safety standards;

(2) basic physical plant standards;

(3) medication management and other ancillary services that might be provided by EIDBI providers;

(4) privacy and the use of cameras in settings where EIDBI services are being provided;

(5) third-party billing procedures and requirements;

(6) billing standards and policies regarding duplicative, simultaneous, and mid-point billing practices;

(7) measures of clinical effectiveness; and

(8) appropriate restrictions on the commissioner's authority under Minnesota Statutes, section 256B.0949, subdivision 17, to issue exceptions to EIDBI provider qualifications, medical assistance provider enrollment requirements, and EIDBI provider or agency standards or requirements.

(c) By January 1, 2027, the commissioner must propose standards for a nonprovisional, comprehensive EIDBI license or licenses, and submit proposed draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over EIDBI services.

Sec. 87. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; TEMPORARY MORATORIUM ON ENROLLMENT OF NEW EIDBI PROVIDERS.**

Upon federal approval and subject to continued federal approval, beginning July 1, 2025, the commissioner must not enroll new EIDBI agencies to provide EIDBI services under

Minnesota Statutes, chapter 256B, unless the agency is licensed as an EIDBI agency under Minnesota Statutes, chapter 245A, but may enroll new locations where EIDBI services are provided by an agency that was enrolled prior to July 1, 2025.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 88. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; INCREASE TO PAYMENTS FOR FAMILY RESIDENTIAL AND LIFE SHARING SERVICES.**

Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner of human services must increase by 51.69 percent payment rates previously established under Minnesota Statutes, section 256B.4914, subdivision 19, for family residential services. Rates for life sharing services must be ten percent higher than the corresponding family residential services rate established under this section.

Sec. 89. **COMMISSIONER OF HUMAN SERVICES; WAIVER CASE MANAGEMENT EVALUATION AND RATE STUDY.**

Subdivision 1. **Reimbursement rate study.** The commissioner of human services must issue a request for proposals to develop and model a proposed reimbursement rate methodology for waiver case management services under Minnesota Statutes, sections 256B.0913, 256B.092, 256B.0922, and 256B.49, and Minnesota Statutes, chapter 256S. The proposed methodology for waiver case management reimbursement rates must be predicated on a methodology that is transparent, culturally responsive, and supportive of lead agency staffing needed to provide high-quality, person-centered, and culturally responsive case management services. The development of the rate methodology must consider costs and workforce pressures that impact the delivery of case management services; costs to provide culturally responsive case management services as described in Minnesota Statutes, section 256B.076, subdivision 3; and compensation required to attract and retain qualified case managers.

Subd. 2. **Evaluation of case management service delivery.** The commissioner must conduct an evaluation of lead agency duties associated with waiver case management; current caseloads; best practices related to caseloads and case mix; required professional qualifications, experience, and training of case management professionals; and quality assurance measures, and make recommendations to improve the quality, consistency, and timeliness of the provision of waiver case management services.

Subd. 3. **Community engagement.** (a) The commissioner must consult with interested parties from across each region of the state including, but not limited to, lead agencies, contracted waiver case management service providers, culturally responsive providers, individuals receiving services and their families, advocacy organizations, and relevant experts in the development of the request for proposals under subdivision 1.

(b) The commissioner must collaborate with interested parties from across each region of the state including, but not limited to, lead agencies, contracted waiver case management

service providers, culturally responsive providers, individuals receiving services and their families, advocacy organizations, and relevant experts in the evaluation of the delivery of waiver case management services.

Subd. 4. **Recommendations and reports.** By December 15, 2025, the commissioner of human services must submit a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance on the initial results of the rate study and service delivery evaluation. By December 15, 2026, the commissioner of human services must submit to the chairs and ranking minority members of committees with jurisdiction over health and human services a report detailing (1) the waiver rate methodology, including all rate components, and modeled rates; and (2) findings and recommendations of the evaluation of case management service delivery. The report must include (1) legislative language necessary to modify existing or implement new rate methodologies and a detailed fiscal analysis of the proposed rate methodology; and (2) legislative language necessary to implement recommendations to improve wavier case management service delivery.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 90. **CHAPTER 245D PROVIDER LICENSING TIMELINESS IMPROVEMENT INITIATIVE.**

(a) The commissioner of human services must conduct a comprehensive business process analysis and redesign of the provider licensing system with a particular focus on Minnesota Statutes, chapter 245D, licensing activities.

(b) The commissioner's business process analysis must include at least the following elements:

(1) a full mapping of the current provider licensing process, including provider inquiry, application intake, documentation requirements, inspections, background checks, approval or denial, and renewal processes;

(2) identification of all bottlenecks, backlogs, batches, redundancies, and inefficiencies;

(3) engagement with providers, people receiving services, lead agencies, and advocates and other stakeholders to gather feedback on process challenges and recommendations for improvement; and

(4) analysis of opportunities to incorporate digital and tech solutions or workflow automation.

(c) When developing a proposal to redesign Minnesota Statutes, chapter 245D, licensing processes to better service individuals and providers, the commissioner must work directly with licensing staff, managers, and leadership and develop revised performance metrics and timelines, including a target average time frame for initial license decisions and renewals with the creation of a dashboard assuring transparency and ongoing accountability.

Sec. 64. **REPEALER.**

(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 effective the day following final enactment.

(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 the day following final enactment.

(d) By January 1, 2026, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services licensing and over long-term services and supports a report that includes:

(1) the findings of the analysis of current Minnesota Statutes, chapter 245D, provider licensing processes;

(2) the proposed redesign of Minnesota Statutes, chapter 245D, provider licensing processes;

(3) an implementation plan of agreed upon improvements with timelines and required resources; and

(4) recommended statutory or regulatory changes, if any, necessary to support implementation.

Sec. 91. **REPEALER.**

Subdivision 1. **Obsolete home and community-based services licensing provisions.** Minnesota Statutes 2024, section 245A.042, subdivisions 2, 3, and 4, are repealed.

Subd. 2. **Direct care provider premiums.** Laws 2023, chapter 59, article 3, section 11, is repealed.

Subd. 3. **Legislative Task Force on Guardianship.** Laws 2024, chapter 127, article 46, section 39, is repealed.

Subd. 4. **Revision of treatment modalities.** Minnesota Statutes 2024, section 256B.0949, subdivision 9, is repealed.

EFFECTIVE DATE. This section is effective July 1, 2025.