

SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 4476

(SENATE AUTHORS: HOFFMAN)		
DATE	D-PG	OFFICIAL STATUS
03/17/2026	6741	Introduction and first reading Referred to Human Services
04/21/2026	8759a	Comm report: To pass as amended and re-refer to Finance
05/04/2026	9496a	Comm report: To pass as amended
	9703	Second reading
	9704	Author stricken Rasmusson
05/06/2026	9946a	Special Order: Amended
	9967	Third reading Passed as amended
05/12/2026	10414	Returned from House with amendment
	10415	Senate not concur, conference committee requested
	10535	Senate conferees Hoffman; Fateh; Wiklund; Abeler
05/13/2026	10539	House conferees Schomaker; Gillman; Noor; Keeler
05/17/2026	11364c	Conference committee report, delete everything
	11658	Senate adopted CC report and repassed bill
	11659	Third Reading Repassed

1.1

A bill for an act

1.2

relating to state government; modifying provisions relating to continuity of care,

1.3

long-term care facilities, health care, Department of Human Services Office of

1.4

Inspector General policy, background studies, uniform services standards, aging

1.5

and disability services, and electronic visit verification; making conforming

1.6

changes; authorizing rulemaking; providing for civil penalties; requiring reports;

1.7

appropriating money; amending Minnesota Statutes 2024, sections 13.46,

1.8

subdivision 7; 142E.16, by adding a subdivision; 144.1503, subdivision 7; 144.294,

1.9

subdivision 2; 144A.291, subdivision 2; 144A.471, subdivision 8; 144G.15;

1.10

144G.16, by adding a subdivision; 144G.195, subdivision 1; 144G.45, subdivision

1.11

3; 245.095, subdivisions 2, 5, as amended, by adding a subdivision; 245.096;

1.12

245.462, by adding a subdivision; 245.4661, subdivision 10, by adding subdivisions;

1.13

245.4711, subdivision 5; 245.4881, subdivision 5; 245.4882, subdivision 6; 245.735,

1.14

subdivision 6; 245A.02, subdivisions 5a, 13; 245A.04, subdivisions 2, 2a;

1.15

245A.042, by adding a subdivision; 245A.043, subdivision 2; 245A.07, subdivision

1.16

2a; 245A.10, by adding a subdivision; 245A.26, subdivisions 3, 4, 5; 245A.65,

1.17

subdivision 1a; 245C.02, subdivision 18; 245C.03, subdivisions 1, 3a, 9, by adding

1.18

subdivisions; 245C.04, subdivision 1; 245C.10, subdivision 8; 245C.15,

1.19

subdivisions 2, 3, 4; 245C.24, subdivision 2; 245D.04, subdivision 3; 245D.081,

1.20

subdivision 3; 245D.10, subdivision 4; 245D.12; 245G.03, subdivision 1; 245I.011,

1.21

subdivisions 3, 5, by adding a subdivision; 245I.02, subdivisions 33, 39, by adding

1.22

subdivisions; 245I.03, subdivision 4, by adding a subdivision; 245I.06, subdivisions

1.23

1, 2; 245I.07; 245I.10, subdivisions 6, as amended, 8, by adding a subdivision;

1.24

245I.23, subdivisions 4, 5, 8, 12, 16, 17; 254A.03, subdivision 2; 254B.17; 256.01,

1.25

subdivision 21, by adding a subdivision; 256.975, subdivision 7b; 256B.02, by

1.26

adding a subdivision; 256B.04, subdivisions 5, 10, 23, by adding subdivisions;

1.27

256B.0623, subdivisions 1, 3, 12, by adding a subdivision; 256B.0624, subdivisions

1.28

1, 4, as amended, by adding a subdivision; 256B.0625, subdivision 17b, by adding

1.29

a subdivision; 256B.064, subdivisions 1b, 1c, 1d, 2, 3, 4, 5, by adding subdivisions;

1.30

256B.0651, subdivision 17; 256B.0659, subdivisions 12, 16, 17, 19; 256B.0671,

1.31

by adding a subdivision; 256B.073, subdivisions 1, 2, 3, 5, by adding subdivisions;

1.32

256B.076, subdivision 1, by adding subdivisions; 256B.0761, subdivisions 2, 3;

1.33

256B.0911, subdivision 32, as amended; 256B.092, subdivision 14; 256B.0922,

1.34

by adding a subdivision; 256B.094, subdivisions 2, 3, 6; 256B.0943, subdivision

1.35

2, by adding a subdivision; 256B.0949, subdivision 17, by adding a subdivision;

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256B.27, subdivision 3; 256B.49, subdivision 25; 256B.4912, by adding

1.37

subdivisions; 256B.4914, subdivisions 6, 6a, 6c, 6d, 7b, 9a, 13, by adding

1.38

subdivisions; 256B.492, by adding a subdivision; 256B.69, subdivisions 5a, 37,

by adding subdivisions; 256B.85, subdivision 23a, by adding subdivisions; 256S.15, by adding a subdivision; 256S.21, by adding subdivisions; 297E.02, subdivision 3; Minnesota Statutes 2025 Supplement, sections 15.013, by adding a subdivision; 144.0724, subdivision 11; 245.4661, subdivision 9; 245.4835, subdivision 2; 245.4871, subdivision 4; 245.735, subdivision 4d; 245A.03, subdivision 2; 245A.04, subdivisions 1, as amended, 7; 245A.043, subdivision 2a; 245A.05; 245A.07, subdivision 3; 245A.10, subdivisions 3, 4; 245A.142, subdivision 3; 245A.242, subdivision 2; 245C.02, subdivision 15a; 245C.05, subdivision 5; 245C.07; 245C.13, subdivision 2; 245C.15, subdivision 4a; 245C.16, subdivision 1; 245C.22, subdivision 5; 245I.04, subdivisions 5, 17, as amended; 245I.06, subdivision 3; 245I.23, subdivisions 7, 10; 254B.02, subdivision 5; 254B.0503, subdivision 1; 254B.0505, by adding a subdivision; 254B.0509, subdivision 2; 256.01, subdivision 2; 256.4792, subdivisions 1, 7, by adding a subdivision; 256B.04, subdivision 21, as amended; 256B.0625, subdivisions 5m, as amended, 17, 18i, 20; 256B.0659, subdivision 21; 256B.0701, subdivision 9; 256B.0911, subdivision 30; 256B.0924, subdivision 6, as amended; 256B.0943, subdivisions 3, 12; 256B.0949, subdivision 16, as amended; 256B.4914, subdivisions 3, 5a, 8, 9; 256B.85, subdivisions 7, 12, 17a; 256I.04, subdivision 2a; 256L.03, subdivision 5, as amended; 260E.03, subdivision 6; 260E.11, subdivision 1; 260E.14, subdivision 1; 626.5572, subdivision 13, as amended; Laws 2021, First Special Session chapter 7, article 13, section 73, as amended; Laws 2025, First Special Session chapter 3, article 8, section 43; article 20, section 19, subdivision 1; article 21, section 3, subdivision 2; Laws 2025, First Special Session chapter 9, article 4, sections 2; 23; 38; 39; 40; 41; 42; 43; 44; 50; 57; Laws 2026, chapter 95, article 4, section 2; article 5, section 23, subdivision 7; proposing coding for new law in Minnesota Statutes, chapters 245A; 245I; 256B; 256R; repealing Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23, subdivision 23; 256B.055, subdivision 14; 256B.0623, subdivisions 2, 4, 5, 6, 9; 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, 11; 256B.073, subdivision 4; 256B.0911, subdivision 21; 256B.0921; 256B.0943, subdivisions 4, 5, 5a, 6, 7, 11; Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3, 4d; 245A.10, subdivision 3a; 256B.0701, subdivision 11; 256B.0911, subdivisions 24a, 25a; 256B.0943, subdivisions 1, 9; Minnesota Rules, part 9505.2165, subpart 4.

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

ARTICLE 1

CONTINUITY OF CARE

Section 1. [256B.045] CONTINUITY OF CARE.

Subdivision 1. **Definitions.** (a) For purposes of this section and section 256B.046, the following terms have the meanings given.

(b) "Administrative action" means an action undertaken by the commissioner to sanction a provider or obtain monetary recovery under section 256B.064, suspend or revoke a provider's license under section 245A.07, or initiate a payment withhold under section 245.095 or 256B.064.

(c) "Complex transition" means that a recipient, without intensive transition planning and coordination, is likely to experience or has experienced an avoidable hospitalization,

institutionalization, serious clinical deterioration, or loss of housing as a result of an administrative action or serious operational event.

(d) "Lead agency" means the county, Tribe, or managed care organization responsible for administering medical assistance to a recipient.

(e) "Recipient" means an enrollee, participant, resident, or other individual receiving community residential services, family residential services, customized living, 24-hour customized living, integrated community supports, residential substance use disorder treatment services, or residential mental health treatment services under medical assistance.

(f) "Serious operational event" means insolvency, receivership, bankruptcy, abandonment, inability of a provider to safely operate, or any other circumstances disrupting a provider's ability to continue to provide services or operate a service setting.

Subd. 2. **Provider duties.** (a) If a medical assistance service provider determines it is unable to continue to provide services to a recipient due to a serious operational event, the provider must:

(1) notify each recipient; each recipient's responsible party, if applicable; the lead agency; and the commissioner as soon as possible but no later than 30 days before terminating services to each recipient;

(2) fully cooperate with the commissioner and lead agency in supporting each recipient in transitioning to another provider of each recipient's choice; and

(3) provide each recipient with a copy of the relevant recipient bill of rights or recipient protections, if applicable, as soon as possible but no later than 30 days before terminating services.

(b) Nothing in this section absolves a provider of its obligations under chapters 144A, 144G, 245A, 245D, 245I, and 245G with respect to service suspensions, service terminations, contract terminations, and coordinated moves. The commissioner of health, the commissioner of human services, or both, may impose any sanctions available under law for violations of state statute or a licensing requirement even if the provider complies with this section and section 256B.046.

Subd. 3. **Lead agency duties.** (a) When a provider is subject to an administrative action or serious operational event, the lead agency must:

(1) inform the appropriate ombudsperson's office for each recipient currently receiving services, if applicable, that the recipient's service provider is subject to an administrative action or is experiencing a serious operational event; and

4.1 (2) directly notify each recipient who receives services from the provider that the
4.2 recipient's service provider is subject to an administrative action or is experiencing a serious
4.3 operational event.

4.4 (b) When a service provider provides notice under subdivision 2 that it is unable to
4.5 continue to provide services to a recipient due to an administrative action or serious
4.6 operational event, the lead agency must assist the provider in developing a continuity of
4.7 care plan to facilitate the recipient's transition to another provider of the recipient's choice.
4.8 The continuity of care plan must be developed through a person-centered process and include
4.9 alternative service options, settings, and service providers with known service capacity.
4.10 The lead agency must complete and receive approval from the recipient of the continuity
4.11 of care plan no later than 14 days following the notification under subdivision 2.

4.12 (c) When a lead agency identifies a recipient's transition as a complex transition under
4.13 section 256B.046, the lead agency must develop a complex transition plan and cooperate
4.14 with and provide information to the commissioner as requested so that the commissioner
4.15 can ensure each recipient receives continuity of medically necessary services and supports
4.16 through a safe and orderly transition to an appropriate alternative service provider.

4.17 (d) Nothing in this section prohibits the lead agency from contacting the commissioner
4.18 or continuity of care team established in subdivision 4 to request support in ensuring
4.19 continuity of care.

4.20 Subd. 4. **Commissioner's duties.** (a) When the commissioner takes an administrative
4.21 action against a provider, the commissioner must endeavor to contact the lead agency
4.22 administering services for potentially affected recipients as soon as practicable and no later
4.23 than 30 days prior to the administrative action becoming effective. The commissioner must
4.24 ensure that the lead agency is taking appropriate steps to ensure continuity of care and that
4.25 the affected recipients will:

4.26 (1) continue to receive needed medically necessary services and supports;

4.27 (2) be given free choice of service, service setting, and service provider if the recipient
4.28 transfers to another service, service setting, or service provider; and

4.29 (3) secure safe and stable housing.

4.30 (b) The commissioner must establish and maintain a continuity of care team to support
4.31 continuity of care efforts by lead agencies and providers. The continuity of care team must
4.32 include personnel from across the Department of Human Services with roles in monitoring
4.33 and supporting providers and lead agencies, establishing standards for continuity of care,

supporting transition planning processes for individuals with a complex transition designation, and overseeing licensing and program integrity efforts. The commissioner may include personnel from other state agencies and housing support providers necessary to effectively carry out the duties of the continuity of care team.

(c) The continuity of care team must provide support, oversight, and direction to lead agencies and providers when a recipient's transition is identified as a complex transition under section 256B.046.

(d) Nothing in this section prohibits the continuity of care team from providing support to lead agencies, providers, and recipients on continuity of care efforts not covered by this section or section 256B.046.

Sec. 2. **[256B.046] COMPLEX TRANSITIONS.**

Subdivision 1. **Complex transition identification.** (a) The lead agency must work with the provider and commissioner to identify each recipient whose transition is a complex transition. The lead agency and provider must submit to the commissioner a complex transition plan as described in subdivision 2 for each recipient identified under this paragraph.

(b) The commissioner may establish objective thresholds to create a presumption of complex transition based on the number of recipients affected by a serious operational event or administrative action, recipient acuity, service type, or unresolved discharge or placement barriers.

Subd. 2. **Complex transition plan.** (a) The commissioner must develop guidance on effective complex transition planning and make a complex transition plan template available to providers and lead agencies. The plan template must include data fields to collect at least the following information:

(1) recipient's name and acuity level;

(2) stabilization actions to be taken to prevent gaps in care and housing;

(3) names, contact information, and known capacity of alternative providers;

(4) transition timelines, transportation, and handoff procedures;

(5) a communication plan for each recipient, the recipient's family, and the recipient's guardian, if applicable, including language access; and

(6) steps to be taken to coordinate with lead agencies, case managers, and ombudsperson offices, when applicable.

6.1 (b) Providers and lead agencies must use the plan template described in paragraph (a)
6.2 to develop a complex transition plan for each recipient whose transition is identified as a
6.3 complex transition.

6.4 Subd. 3. **Complex transition planning.** (a) A lead agency that receives notice from a
6.5 provider of a serious operational event must assist a recipient with an identified complex
6.6 transition to develop a complex transition plan through a person-centered process. The
6.7 complex transition plan must include alternative service options, service settings, service
6.8 providers with known service capacity, and safe and stable housing options. Within 14 days
6.9 of receiving notice from a provider of a serious operational event, the lead agency must
6.10 ensure completion and approval of the complex transition plan by the recipient or the
6.11 recipient's representative.

6.12 (b) A lead agency that receives notice from the commissioner of an administrative action
6.13 must assist a recipient with an identified complex transition to develop a complex transition
6.14 plan through a person-centered process. The complex transition plan must include alternative
6.15 service options, service settings, service providers with known service capacity, and safe
6.16 and stable housing options. Within 14 days of receiving notice from the commissioner of
6.17 an administrative action, other than notice of actions necessary to protect the health and
6.18 safety of a recipient, the lead agency must ensure completion and approval of the complex
6.19 transition plan by the recipient or the recipient's representative. For any administrative action
6.20 necessary to protect the health and safety of a recipient, the lead agency must immediately
6.21 take all necessary actions to ensure the health and safety of the recipient.

6.22 (c) Lead agencies must, as soon as possible, convene a meeting of representatives of the
6.23 recipient; the recipient's representative, if appropriate; the lead agency; the provider, if the
6.24 commissioner determines the provider's participation is appropriate; and the commissioner
6.25 to discuss implementation of the complex transition plan.

6.26 (d) While a complex transition plan is active, lead agencies must convene every 14 days
6.27 for a status meeting to provide a progress report to the commissioner on implementation of
6.28 the complex transition plan.

6.29 Subd. 4. **No alternative services notification.** (a) If the lead agency does not identify
6.30 an alternative service option, service setting, service provider, or safe and stable housing
6.31 option, the lead agency must notify the commissioner and the commissioner of health, if
6.32 applicable.

6.33 (b) Upon receiving a notification from the lead agency that the lead agency has failed
6.34 to arrange for an alternative service option, service setting, service provider, or safe and

7.1 stable housing option as required under the complex transition plan, the commissioner must
7.2 determine if:

7.3 (1) there exists a good cause under Code of Federal Regulations, title 42, section 455.23(e)
7.4 or (f), to not suspend payments under section 256B.064, subdivision 2;

7.5 (2) a delay in the implementation date of an administrative action is needed to support
7.6 complex transition planning under this section; or

7.7 (3) there is cause to petition the district court in Ramsey County under section 245A.13
7.8 to be appointed receiver to operate a residential program.

7.9 Subd. 5. **Publishing data on continuity of care planning and complex transitions.** (a)
7.10 The commissioner must maintain on the Department of Human Services' website a dashboard
7.11 sharing data on the:

7.12 (1) number of active continuity of care plans;

7.13 (2) number of recipients included in an active continuity of care plan;

7.14 (3) average time between approval of a continuity of care plan and closure of that plan;

7.15 (4) number of active complex transition plans;

7.16 (5) number of complex transition plans completed before the provider ceases providing
7.17 services or closes a setting, on an annual basis;

7.18 (6) number of complex transition plans completed after the provider ceases providing
7.19 services or closes a setting, on an annual basis;

7.20 (7) number of complex transition plans that were not successfully completed, on an
7.21 annual basis;

7.22 (8) number of notifications received by lead agencies under subdivision 3, paragraph
7.23 (a); and

7.24 (9) number of notifications received by lead agencies under subdivision 3, paragraph
7.25 (b).

7.26 (b) The commissioner must include functionality within the dashboard to filter data by
7.27 region or county, provided the filtering functionalities comply with federal or state laws
7.28 regarding the protection of personal health information and personally identifiable
7.29 information.

8.1 Sec. 3. Minnesota Statutes 2024, section 256B.0651, subdivision 17, is amended to read:

8.2 Subd. 17. **Recipient protection.** ~~(a) Providers of home care services must provide each~~
8.3 ~~recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days~~
8.4 ~~prior to terminating services to a recipient, if the termination results from provider sanctions~~
8.5 ~~under section 256B.064, such as a payment withhold, a suspension of participation, or a~~
8.6 ~~termination of participation. If a home care provider determines it is unable to continue~~
8.7 ~~providing services to a recipient, the provider must notify the recipient, the recipient's~~
8.8 ~~responsible party, and the commissioner 30 days prior to terminating services to the recipient~~
8.9 ~~because of an action under section 256B.064, and must assist the commissioner and lead~~
8.10 ~~agency in supporting the recipient in transitioning to another home care provider of the~~
8.11 ~~recipient's choice~~ meet the recipient protection requirements under section 256B.045 when
8.12 subject to an administrative action or a serious operational event as defined in section
8.13 256B.045, subdivision 1.

8.14 ~~(b) In the event of a payment withhold from a home care provider, a suspension of~~
8.15 ~~participation, or a termination of participation of a home care provider under section~~
8.16 ~~256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care~~
8.17 ~~and the lead agencies for all recipients with active service agreements with the provider. At~~
8.18 ~~the commissioner's request, the lead agencies must contact recipients to ensure that the~~
8.19 ~~recipients are continuing to receive needed care, and that the recipients have been given~~
8.20 ~~free choice of provider if they transfer to another home care provider. In addition, the~~
8.21 ~~commissioner or the commissioner's delegate may directly notify recipients who receive~~
8.22 ~~care from the provider that payments have been or will be withheld or that the provider's~~
8.23 ~~participation in medical assistance has been or will be suspended or terminated, if the~~
8.24 ~~commissioner determines that notification is necessary to protect the welfare of the recipients.~~
8.25 ~~For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care~~
8.26 ~~organizations.~~

8.27 Sec. 4. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision to
8.28 read:

8.29 Subd. 38. **Duties when a provider is no longer able to provide services.** When a
8.30 provider is subject to a serious operational event or administrative action under section
8.31 256B.045, managed care and county-based purchasing plans must:

8.32 (1) follow the continuity of care planning and complex transition planning requirements
8.33 under sections 256B.045 and 256B.046;

- 9.1 (2) honor existing services authorizations when clinically appropriate for continuity and
9.2 safe transfer of services; and
- 9.3 (3) ensure timely contracting or single-case arrangements to prevent services gaps.

9.4 Sec. 5. Minnesota Statutes 2024, section 256B.85, subdivision 23a, is amended to read:

9.5 Subd. 23a. **Sanctions; information for participants upon termination of services.** (a)
9.6 The commissioner may withhold payment from the provider or suspend or terminate the
9.7 provider enrollment number if the provider fails to comply fully with applicable laws or
9.8 rules. The provider has the right to appeal the decision of the commissioner under section
9.9 256B.064.

9.10 (b) Notwithstanding subdivision 13, paragraph (e), if a participant employer fails to
9.11 comply fully with applicable laws or rules, the commissioner may disenroll the participant
9.12 from the budget model. A participant may appeal in writing to the department under section
9.13 256.045, subdivision 3, to contest the department's decision to disenroll the participant from
9.14 the budget model.

9.15 (c) Agency-providers of CFSS services or FMS providers must ~~provide each participant~~
9.16 ~~with a copy of participant protections in subdivision 20e at least 30 days prior to terminating~~
9.17 ~~services to a participant, if the termination results from sanctions under this subdivision or~~
9.18 ~~section 256B.064, such as a payment withhold or a suspension or termination of the provider~~
9.19 ~~enrollment number. If a CFSS agency provider, FMS provider, or consultation services~~
9.20 ~~provider determines it is unable to continue providing services to a participant because of~~
9.21 ~~an action under this subdivision or section 256B.064, the agency provider, FMS provider,~~
9.22 ~~or consultation services provider must notify the participant, the participant's representative,~~
9.23 ~~and the commissioner 30 days prior to terminating services to the participant, and must~~
9.24 ~~assist the commissioner and lead agency in supporting the participant in transitioning to~~
9.25 ~~another CFSS agency provider, FMS provider, or consultation services provider of the~~
9.26 ~~participant's choice~~ meet the recipient protection requirements under section 256B.045 when
9.27 subject to an administrative action or a serious operational event as defined in section
9.28 256B.045, subdivision 1.

9.29 ~~(d) In the event the commissioner withholds payment from a CFSS agency provider,~~
9.30 ~~FMS provider, or consultation services provider, or suspends or terminates a provider~~
9.31 ~~enrollment number of a CFSS agency provider, FMS provider, or consultation services~~
9.32 ~~provider under this subdivision or section 256B.064, the commissioner may inform the~~
9.33 ~~Office of Ombudsman for Long-Term Care and the lead agencies for all participants with~~
9.34 ~~active service agreements with the agency provider, FMS provider, or consultation services~~

~~provider. At the commissioner's request, the lead agencies must contact participants to ensure that the participants are continuing to receive needed care, and that the participants have been given free choice of agency provider, FMS provider, or consultation services provider if they transfer to another CFSS agency provider, FMS provider, or consultation services provider. In addition, the commissioner or the commissioner's delegate may directly notify participants who receive care from the agency provider, FMS provider, or consultation services provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that the notification is necessary to protect the welfare of the participants.~~

Sec. 6. **HOUSING SUPPORT CAPACITY-BUILDING GRANTS.**

(a) The commissioner of human services must establish capacity-building grants for housing support providers assisting recipients of medical assistance home and community-based services, including but not limited to integrated community supports, to prevent homelessness and institutionalization. The commissioner must award at least one grant to a qualified grant recipient located outside of the seven-county metropolitan area. The commissioner must include in the grant contract that the money awarded under the grant must not be used for any purpose other than the purposes specified in paragraph (c).

(b) Eligible recipients include housing support providers operating in accordance with Minnesota Statutes, section 256I.04.

(c) Capacity-building grants may be used for:

(1) administrative expenses;

(2) the assessment of eligible housing assistance benefits;

(3) housing transition assistance, including supports required due to a change in an individual's medical assistance services or provider; and

(4) the development of regional or collaborative housing support models that enable housing support providers to better support individual choice and access to community-integrated housing options.

(d) Grant recipients must report data and results to the commissioner, in a format determined by the commissioner, including:

(1) the percent increase in provider capacity;

11.1 (2) the number of referrals received and accepted, by medical assistance home and
 11.2 community-based service type;

11.3 (3) reasons for a referral;

11.4 (4) housing status for all accepted referrals at six months and one year, including the
 11.5 number of individuals residing in community-based settings; and

11.6 (5) additional outcomes as necessary to evaluate the effectiveness of the programs and
 11.7 use of funding for the people served.

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

11.9 Sec. 7. **DIRECTION TO COMMISSIONER; CONTINUITY OF CARE POLICIES**
 11.10 **AND PROCEDURES.**

11.11 The commissioner of human services must develop policies and procedures lead agencies
 11.12 must follow when developing, implementing, monitoring, and closing a complex transition
 11.13 plan under Minnesota Statutes, section 256B.046. The policies and procedures must include
 11.14 timelines, checklists, and mandatory follow-up with all parties involved in the development
 11.15 and implementation of the plan. The policies and procedures must include documentation
 11.16 requirements sufficient to demonstrate that the planning process and implementation was
 11.17 person-centered and prioritized the needs and informed choice of the service recipient.

11.18 **ARTICLE 2**

11.19 **LONG-TERM CARE FACILITY**

11.20 Section 1. Minnesota Statutes 2024, section 144.1503, subdivision 7, is amended to read:

11.21 Subd. 7. **Selection process.** The commissioner shall determine a maximum award for
 11.22 grants and loan forgiveness, and shall make selections based on the information provided
 11.23 in the grant application, including the demonstrated need for an applicant provider to enhance
 11.24 the education of its workforce, the proposed employee scholarship or loan forgiveness
 11.25 selection process, the applicant's proposed budget, and other criteria as determined by the
 11.26 commissioner. Notwithstanding any law or rule to the contrary, amounts appropriated for
 11.27 purposes of this section do not cancel and are available until expended, ~~except that at the~~
 11.28 ~~end of each biennium, any remaining amount that is not committed by contract and not~~
 11.29 ~~needed to fulfill existing commitments shall cancel to the general fund.~~

12.1 Sec. 2. Minnesota Statutes 2024, section 144A.291, subdivision 2, is amended to read:

12.2 Subd. 2. **Amounts.** (a) Fees may not exceed the following amounts but may be adjusted
12.3 lower by board direction and are for the exclusive use of the board as required to sustain
12.4 board operations. The maximum amounts of fees are:

12.5 (1) application for licensure, \$200;

12.6 (2) for a prospective applicant for a review of education and experience advisory to the
12.7 license application, \$100, to be applied to the fee for application for licensure if the latter
12.8 is submitted within one year of the request for review of education and experience;

12.9 (3) state examination, \$125;

12.10 (4) initial license, \$250 ~~if issued between July 1 and December 31, \$100 if issued between~~
12.11 ~~January 1 and June 30;~~

12.12 (5) ~~acting~~ permit, \$400;

12.13 (6) renewal license or certificate, \$250;

12.14 (7) duplicate license, permit, or certificate, \$50;

12.15 (8) reinstatement fee, \$250;

12.16 ~~(9) health services executive initial license, \$250;~~

12.17 ~~(10) health services executive renewal license, \$250;~~

12.18 ~~(11)~~ (9) reciprocity verification fee, \$50;

12.19 ~~(12) second~~ (10) application for shared assignment certificate, \$250;

12.20 ~~(13)~~ (11) continuing education fees:

12.21 (i) greater than six hours, \$50; and

12.22 (ii) seven hours or more, \$75;

12.23 ~~(14)~~ (12) education review, \$100;

12.24 ~~(15)~~ (13) fee to a sponsor for review of individual continuing education seminars,
12.25 institutes, workshops, or home study courses:

12.26 (i) for less than seven clock hours, \$30; and

12.27 (ii) for seven or more clock hours, \$50;

13.1 ~~(16)~~ (14) fee to a licensee for review of continuing education seminars, institutes,
 13.2 workshops, or home study courses not previously approved for a sponsor and submitted
 13.3 with an application for license renewal:

13.4 (i) for less than seven clock hours total, \$30; and

13.5 (ii) for seven or more clock hours total, \$50;

13.6 ~~(17)~~ (15) late renewal fee, \$75;

13.7 ~~(18)~~ (16) fee to a licensee for verification of licensure status and examination scores,
 13.8 \$30;

13.9 ~~(19)~~ (17) registration as a registered continuing education sponsor, \$1,000;

13.10 ~~(20)-mail~~ (18) mailing list labels, \$75; and

13.11 ~~(21)~~ (19) annual assisted living program education provider fee, \$2,500.

13.12 (b) The revenue generated from the fees must be deposited in an account in the state
 13.13 government special revenue fund.

13.14 Sec. 3. Minnesota Statutes 2024, section 144A.471, subdivision 8, is amended to read:

13.15 Subd. 8. **Exemptions from home care services licensure.** (a) Except as otherwise
 13.16 provided in this chapter, home care services that are provided by the state, counties, or other
 13.17 units of government must be licensed under this chapter.

13.18 (b) An exemption under this subdivision does not excuse the exempted individual or
 13.19 organization from complying with applicable provisions of the home care bill of rights in
 13.20 section 144A.44. The following individuals or organizations are exempt from the requirement
 13.21 to obtain a home care provider license:

13.22 (1) an individual or organization that offers, provides, or arranges for personal care
 13.23 assistance services under the medical assistance program as authorized under sections
 13.24 256B.0625, subdivision 19a, and 256B.0659;

13.25 (2) a provider that is licensed by the commissioner of human services to provide
 13.26 semi-independent living services for persons with developmental disabilities under section
 13.27 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

13.28 (3) a provider that is licensed by the commissioner of human services to provide home
 13.29 and community-based services for persons with developmental disabilities under section
 13.30 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

(4) an individual or organization that provides only home management services, if the individual or organization is registered under section 144A.482; ~~or~~

(5) an individual who is licensed in this state as a nurse, dietitian, social worker, occupational therapist, physical therapist, or speech-language pathologist who provides health care services in the home independently and not through any contractual or employment relationship with a home care provider or other organization; or

(6) a federally qualified health center as defined in section 145.9269, when providing nursing services described in United States Code, title 42, section 1395x(aa)(1)(C).

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

Sec. 4. Minnesota Statutes 2024, section 144G.15, is amended to read:

144G.15 CONSIDERATION OF APPLICATIONS.

Subdivision 1. **Consideration.** (a) Before issuing a provisional license or license or renewing a license, the commissioner shall consider an applicant's compliance history in providing care in this state or any other state in a facility that provides care to children, the elderly, ill individuals, or individuals with disabilities.

(b) The applicant's compliance history shall include repeat violation, rule violations, and any license or certification involuntarily suspended or terminated during an enforcement process.

(c) Before issuing a provisional license for an assisted living facility with a licensed resident capacity of six or fewer, the commissioner shall also consider the population, size, land use plan, availability of community services, and the number and size of existing licensed assisted living facilities in the town, municipality, or county in which the applicant seeks to operate an assisted living facility.

Subd. 2. **Colocation of certain home and community-based residential settings.** The commissioner must not grant a provisional license for an assisted living facility with a licensed resident capacity of six or fewer until the commissioner of human services determines that the proposed location of the assisted living facility meets the standard described in section 245A.042, subdivision 7. This paragraph applies regardless of the services to be provided in the proposed assisted living facility and regardless of whether any residents of the facility will receive publicly funded services.

Subd. 3. **Grounds for licensing action.** ~~(e)~~ The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license shall be granted;

(2) the applicant, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application or in any matter under investigation by the department;

(3) the applicant refused to allow agents of the commissioner to inspect its books, records, and files related to the license application, or any portion of the premises;

(4) the applicant willfully prevented, interfered with, or attempted to impede in any way: (i) the work of any authorized representative of the commissioner, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities; or (ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the applicant, owner, controlling individual, managerial official, or assisted living director for the facility has a history of noncompliance with federal or state regulations that were detrimental to the health, welfare, or safety of a resident or a client; or

(6) the applicant violates any requirement in this chapter.

~~(d) If a license is denied, the applicant has the reconsideration rights available under section 144G.16, subdivision 4.~~

Sec. 5. Minnesota Statutes 2024, section 144G.16, is amended by adding a subdivision to read:

Subd. 8. **Notice to affected municipality.** (a) No later than five days, excluding weekends and holidays, after issuing a provisional license to an assisted living facility with a licensed resident capacity of six or fewer, the commissioner must provide the following information about the provisional licensee and the facility to the affected municipality or other political subdivision:

(1) business name of the provisional licensee;

(2) street address of the facility;

(3) license category;

(4) licensed resident capacity; and

(5) contact information for an authorized agent of the provisional licensee.

(b) The commissioner may provide notice through electronic communication or by submitting a written document to the official address of the municipality or other political subdivision.

EFFECTIVE DATE. This section is effective July 1, 2026, and applies to provisional licenses issued on or after that date.

Sec. 6. Minnesota Statutes 2024, section 144G.195, subdivision 1, is amended to read:

Subdivision 1. **New license not required.** ~~(a) Beginning March 15, 2025,~~ An assisted living facility with a licensed resident capacity of five residents or fewer may operate under the licensee's current license if the facility is relocated with the approval of the commissioner of health during the period the current license is valid.

(b) A licensee is not required to apply for a new license solely because the licensee receives approval to relocate a facility. The licensee's license for the relocated facility remains valid until the expiration date specified on the existing license. The commissioner of health must apply the licensing and survey cycle previously established for the facility's prior location to the facility's new location.

(c) A licensee must notify the commissioner of health, on a form developed by the commissioner, of the licensee's intent to relocate the licensee's facility and submit a nonrefundable relocation fee of \$3,905. The commissioner must deposit all relocation fees in the state treasury to be credited to the state government special revenue fund.

(d) The licensee must obtain plan review approval for the building to which the licensee intends to relocate the facility and a certificate of occupancy from the commissioner of labor and industry or the commissioner of labor and industry's delegated authority for the building. Upon issuance of a certificate of occupancy, the commissioner of health must review and inspect the building to which the licensee intends to relocate the facility ~~and approve or deny the license relocation within 30 calendar days~~ and must request from the commissioner of human services a determination of whether the location to which the licensee intends to relocate complies with the standards described in section 245A.042, subdivision 7. The commissioner of health must approve or deny the license relocation within 30 calendar days after inspecting the building and receiving a determination from the commissioner of human services.

~~(e) A licensee may only relocate a facility within the geographic boundaries of the municipality in which the facility is currently located or within the geographic boundaries of a contiguous municipality located in the seven-county metropolitan area may not relocate~~

17.1 outside of the seven-county metropolitan area. A licensee located outside of the seven-county
17.2 metropolitan area may not relocate more than two hours or 120 miles from the licensee's
17.3 previous location nor relocate within the seven-county metropolitan area.

17.4 (f) A licensee may only relocate one time in any three-year period, except that the
17.5 commissioner may approve an additional relocation within a three-year period upon a
17.6 licensee's demonstration of an extenuating circumstance, including but not limited to the
17.7 criteria outlined in section 256B.49, subdivision 28a, paragraph (c).

17.8 (g) A licensee that receives approval from the commissioner to relocate a facility must
17.9 provide each resident with a new assisted living contract and comply with the coordinated
17.10 move requirements under section 144G.55.

17.11 (h) A licensee denied approval by the commissioner of health to relocate a facility may
17.12 continue to operate the facility in its current location, follow the requirements in section
17.13 144G.57 and close the facility, or notify the commissioner of health of the licensee's intent
17.14 to relocate the facility to an alternative new location. If the licensee notifies the commissioner
17.15 of the licensee's intent to relocate the facility to an alternative new location, ~~paragraph (e)~~
17.16 applies, including all provisions of this section apply, including paragraph (c) and the
17.17 timelines for approving or denying the license relocation for the alternative new location.

17.18 (i) If the commissioner of health approves a relocation under this subdivision, the
17.19 commissioner must comply with the provisions of section 144G.16, subdivision 8.

17.20 Sec. 7. Minnesota Statutes 2024, section 144G.45, subdivision 3, is amended to read:

17.21 Subd. 3. **Local laws apply; delegating inspection authority.** (a) Assisted living facilities
17.22 shall comply with all applicable state and local governing laws, regulations, standards,
17.23 ordinances, and codes for fire safety, building, and zoning requirements, except a facility
17.24 with a licensed resident capacity of six or fewer is exempt from rental licensing regulations
17.25 imposed by any town, municipality, or county.

17.26 (b) At the request of a county or local unit of government, the commissioner may delegate
17.27 to a county agency or local unit of government the commissioner's authority to inspect an
17.28 existing assisted living facility with a licensed resident capacity of six or fewer that is in
17.29 the jurisdiction of the county or local unit of government for compliance with applicable
17.30 physical plant licensing requirements and zoning ordinances. If the commissioner delegates
17.31 the commissioner's authority to a county agency or local unit of government under this
17.32 subdivision, the commissioner must execute a formal delegation of authority that clearly
17.33 specifies what authority is being delegated to the county agency or local unit of government,

that the commissioner is responsible for any costs incurred by the county agency or local unit of government for conducting inspections under delegated authority, and that the county agency or local unit of government must not assess any additional fees for conducting an inspection under delegated authority. When conducting an inspection under delegated authority, the county agency or local unit of government must provide the subject of the inspection with a copy of the delegation of authority.

(c) When a county agency or local unit of government is conducting an inspection under delegated authority as provided in paragraph (b), the county agency or local unit of government and the commissioner must coordinate their inspections to minimize visits to and disruptions of the facility. A county agency or local unit of government conducting an inspection must notify the commissioner of any violations or concerns within ten working days of the inspection. A county agency or local unit of government that conducts inspections under this subdivision must not inspect an assisted living facility more frequently than annually, except a follow-up inspection is permitted before the next annual inspection to verify correction of a violation discovered during the most recent inspection.

(d) The commissioner must ensure that laws, rules, and codes are uniformly enforced throughout the state by reviewing at least every four years each county agency and local unit of government conducting inspections under this subdivision for compliance with this subdivision and other applicable laws and rules. The commissioner must ensure that a county agency or local unit of government to which the commissioner has delegated the commissioner's authority under this subdivision has at all times sufficient expertise to conduct delegated inspections competently, and if the county agency or local unit of government does not, the commissioner must immediately revoke the delegation of authority.

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

Sec. 8. DIRECTION TO COMMISSIONER OF HEALTH; SMALL ASSISTED LIVING FACILITY LICENSURE.

(a) The commissioner of health must convene a group of interested parties to examine the licensing requirements under Minnesota Statutes, chapter 144G, for assisted living facilities with a licensed resident capacity of five residents or fewer. The group must develop a new licensing category applicable to such facilities to account for health and safety requirements and practical realities of operating small assisted living facilities that predominantly serve individuals receiving customized living services under the federally approved brain injury, community access for disability inclusion, and elderly waiver plans.

(b) The commissioner must develop draft legislative language to establish a new assisted living license category for facilities with a licensed resident capacity of five residents or fewer.

(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, 2028.

ARTICLE 3 HEALTH CARE

Section 1. Minnesota Statutes 2025 Supplement, section 15.013, is amended by adding a subdivision to read:

Subd. 7. **Exemption.** Nothing in this section modifies, supersedes, limits, or expands the authority of the commissioner of human services to impose sanctions under section 256B.064.

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

Sec. 2. Minnesota Statutes 2024, section 245.095, is amended by adding a subdivision to read:

Subd. 7. **Exemption.** Nothing in this section modifies, supersedes, limits, or expands the commissioner's authority to impose sanctions under section 256B.064.

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

Sec. 3. Minnesota Statutes 2024, section 245.462, is amended by adding a subdivision to read:

Subd. 2a. **Case management contact.** "Case management contact" means interactive communication conducted in person, by interactive video that meets the requirements of section 256B.0625, subdivision 20b, or by telephone with the client; client's parent; legal guardian, guardian ad litem, or attorney for clients that are children or youth under 19 years of age; or client's attorney for clients that are adults 19 years of age or older.

Sec. 4. Minnesota Statutes 2024, section 245.4711, subdivision 5, is amended to read:

Subd. 5. **Coordination between case manager and community support services.** (a) The county board must establish procedures that ensure ongoing contact and coordination

20.1 between the case manager and the community support services program as well as other
20.2 mental health services.

20.3 (b) The case manager must have at least one case management contact in every calendar
20.4 month with a documented core service component, as defined by the commissioner, to claim
20.5 reimbursement for adult mental health targeted case management. Adult mental health case
20.6 managers must not conduct the case management contact by telephone with the adult client
20.7 or the adult client's legal representative for more than two consecutive calendar months.

20.8 Sec. 5. Minnesota Statutes 2024, section 245.4881, subdivision 5, is amended to read:

20.9 Subd. 5. **Coordination between case manager and family community support**
20.10 **services.** (a) The county board must establish procedures that ensure ongoing contact and
20.11 coordination between the case manager and the family community support services as well
20.12 as other mental health services for each child.

20.13 (b) The case manager must have at least one case management contact in every calendar
20.14 month with the child, the child's parents, or the child's legal representative.

20.15 Sec. 6. Minnesota Statutes 2024, section 245A.02, subdivision 5a, is amended to read:

20.16 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a
20.17 program or service provider licensed under this chapter and the following individuals, if
20.18 applicable:

20.19 (1) each officer of the organization, including the chief executive officer and chief
20.20 financial officer;

20.21 (2) the individual designated as the authorized agent under section 245A.04, subdivision
20.22 1, paragraph (b);

20.23 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
20.24 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

20.25 (4) each managerial official whose responsibilities include the direction of the
20.26 management or policies of a program; and

20.27 (5) the president and treasurer of the board of directors of a nonprofit corporation.

20.28 (b) Controlling individual does not include:

20.29 (1) a bank, savings bank, trust company, savings association, credit union, industrial
20.30 loan and thrift company, investment banking firm, or insurance company unless the entity
20.31 operates a program directly or through a subsidiary;

21.1 (2) an individual who is a state or federal official, or state or federal employee, or a
21.2 member or employee of the governing body of a political subdivision of the state or federal
21.3 government that operates one or more programs, unless the individual is also an officer,
21.4 owner, or managerial official of the program, receives remuneration from the program, or
21.5 owns any of the beneficial interests not excluded in this subdivision;

21.6 (3) an individual who owns less than five percent of the outstanding common shares of
21.7 a corporation:

21.8 (i) whose securities are exempt under section 80A.45, clause (6); or

21.9 (ii) whose transactions are exempt under section 80A.46, clause (2);

21.10 (4) an individual who is a member of an organization exempt from taxation under section
21.11 290.05, unless the individual is also an officer, owner, or managerial official of the program
21.12 or owns any of the beneficial interests not excluded in this subdivision. This clause does
21.13 not exclude from the definition of controlling individual an organization that is exempt from
21.14 taxation; or

21.15 (5) an employee stock ownership plan trust, or a participant or board member of an
21.16 employee stock ownership plan, unless the participant or board member is a controlling
21.17 individual according to paragraph (a).

21.18 (c) For purposes of this subdivision, "managerial official" means an individual who has
21.19 the decision-making authority related to the operation of the program, and the responsibility
21.20 for the ongoing management of or direction of the policies, services, or employees of the
21.21 program. A site director who has no ownership interest in the program is not considered to
21.22 be a managerial official for purposes of this definition.

21.23 Sec. 7. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 1, as amended
21.24 by Laws 2026, chapter 88, article 1, section 101, is amended to read:

21.25 Subdivision 1. **Application for licensure.** (a) An individual, organization, or government
21.26 entity that is subject to licensure under section 245A.03 must apply for a license. The
21.27 application must be made on the forms and in the manner prescribed by the commissioner.
21.28 The commissioner shall provide the applicant with instruction in completing the application
21.29 and provide information about the rules and requirements of other state agencies that affect
21.30 the applicant. An applicant seeking licensure in Minnesota with headquarters outside of
21.31 Minnesota must have a program office located within 30 miles of the Minnesota border.
21.32 An applicant who intends to buy or otherwise acquire a program or services licensed under
21.33 this chapter that is owned by another license holder must apply for a license under this

22.1 chapter and comply with the application procedures in this section and section 245A.043.
22.2 A license issued pursuant to a change of ownership under section 245A.043 is not subject
22.3 to any moratorium imposed under section 245A.03, subdivision 7 or 7a, provided the change
22.4 of ownership does not result in an increase in licensed capacity or service scope.

22.5 The commissioner shall act on the application within 90 working days after a complete
22.6 application and any required reports have been received from other state agencies or
22.7 departments, counties, municipalities, or other political subdivisions. The commissioner
22.8 shall not consider an application to be complete until the commissioner receives all of the
22.9 required information. If the applicant or a controlling individual is the subject of a pending
22.10 administrative, civil, or criminal investigation, the application is not complete until the
22.11 investigation has closed or the related legal proceedings are complete.

22.12 When the commissioner receives an application for initial licensure that is incomplete
22.13 because the applicant failed to submit required documents or that is substantially deficient
22.14 because the documents submitted do not meet licensing requirements, the commissioner
22.15 shall provide the applicant written notice that the application is incomplete or substantially
22.16 deficient. In the written notice to the applicant the commissioner shall identify documents
22.17 that are missing or deficient and give the applicant 45 days to resubmit a second application
22.18 that is substantially complete. An applicant's failure to submit a substantially complete
22.19 application after receiving notice from the commissioner is a basis for license denial under
22.20 section 245A.05.

22.21 (b) An application for licensure must identify all controlling individuals as defined in
22.22 section 245A.02, subdivision 5a, and must designate one individual to be the authorized
22.23 agent. The application must be signed by the authorized agent and must include the authorized
22.24 agent's first, middle, and last name; mailing address; and email address. By submitting an
22.25 application for licensure, the authorized agent consents to electronic communication with
22.26 the commissioner throughout the application process. The authorized agent must be
22.27 authorized to accept service on behalf of all of the controlling individuals. A government
22.28 entity that holds multiple licenses under this chapter may designate one authorized agent
22.29 for all licenses issued under this chapter or may designate a different authorized agent for
22.30 each license. Service on the authorized agent is service on all of the controlling individuals.
22.31 It is not a defense to any action arising under this chapter that service was not made on each
22.32 controlling individual. The designation of a controlling individual as the authorized agent
22.33 under this paragraph does not affect the legal responsibility of any other controlling individual
22.34 under this chapter.

23.1 (c) An applicant or license holder must have a policy that prohibits license holders,
23.2 employees, subcontractors, and volunteers, when directly responsible for persons served
23.3 by the program, from abusing prescription medication or being in any manner under the
23.4 influence of a chemical that impairs the individual's ability to provide services or care. The
23.5 license holder must train employees, subcontractors, and volunteers about the program's
23.6 drug and alcohol policy before the employee, subcontractor, or volunteer has direct contact,
23.7 as defined in section 245C.02, subdivision 11, with a person served by the program.

23.8 (d) An applicant and license holder must have a program grievance procedure that permits
23.9 persons served by the program and their authorized representatives to bring a grievance to
23.10 the highest level of authority in the program.

23.11 (e) The commissioner may limit communication during the application process to the
23.12 authorized agent or the controlling individuals identified on the license application and for
23.13 whom a background study was initiated under chapter 245C. Upon implementation of the
23.14 provider licensing and reporting hub, applicants and license holders must use the hub in the
23.15 manner prescribed by the commissioner. The commissioner may require the applicant,
23.16 except for child foster care, to demonstrate competence in the applicable licensing
23.17 requirements by successfully completing a written examination. The commissioner may
23.18 develop a prescribed written examination format.

23.19 (f) When an applicant is an individual, the applicant must provide:

23.20 (1) the applicant's taxpayer identification numbers including the Social Security number
23.21 or Minnesota tax identification number, and federal employer identification number if the
23.22 applicant has employees;

23.23 (2) at the request of the commissioner, a copy of the most recent filing with the secretary
23.24 of state that includes the complete business name, if any;

23.25 (3) if doing business under a different name, the doing business as (DBA) name, as
23.26 registered with the secretary of state;

23.27 (4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique
23.28 Minnesota Provider Identifier (UMPI) number; and

23.29 (5) at the request of the commissioner, the notarized signature of the applicant or
23.30 authorized agent.

23.31 (g) When an applicant is an organization, the applicant must provide:

23.32 (1) the applicant's taxpayer identification numbers including the Minnesota tax
23.33 identification number and federal employer identification number;

(2) at the request of the commissioner, a copy of the most recent filing with the secretary of state that includes the complete business name, and if doing business under a different name, the doing business as (DBA) name, as registered with the secretary of state;

(3) the first, middle, and last name, and address for all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual;

(4) if applicable, the applicant's NPI number and UMPI number;

(5) the documents that created the organization and that determine the organization's internal governance and the relations among the persons that own the organization, have an interest in the organization, or are members of the organization, in each case as provided or authorized by the organization's governing statute, which may include a partnership agreement, bylaws, articles of organization, organizational chart, and operating agreement, or comparable documents as provided in the organization's governing statute; and

(6) the notarized signature of the applicant or authorized agent.

(h) When the applicant is a government entity, the applicant must provide:

(1) the name of the government agency, political subdivision, or other unit of government seeking the license and the name of the program or services that will be licensed;

(2) the applicant's taxpayer identification numbers including the Minnesota tax identification number and federal employer identification number;

(3) a letter signed by the manager, administrator, or other executive of the government entity authorizing the submission of the license application; and

(4) if applicable, the applicant's NPI number and UMPI number.

(i) At the time of application for licensure or renewal of a license under this chapter, the applicant or license holder must acknowledge on the form provided by the commissioner if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license that:

(1) the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by the commissioner as part of a licensing investigation or licensing inspection; and

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing

25.1 inspection, or noncompliance with a licensing requirement that is a basis of enrollment for
25.2 reimbursement for a service, may result in:

25.3 (i) a correction order or a conditional license under section 245A.06, or sanctions under
25.4 section 245A.07;

25.5 (ii) nonpayment of claims submitted by the license holder for public program
25.6 reimbursement;

25.7 (iii) recovery of payments made for the service;

25.8 (iv) disenrollment in the public payment program; or

25.9 (v) other administrative, civil, or criminal penalties as provided by law.

25.10 (j) An applicant or license holder who acknowledges under paragraph (i) that the applicant
25.11 or license holder elects to receive any publicly funded reimbursement from the commissioner
25.12 for services provided under the license that are designated by the commissioner as high-risk
25.13 under section 256B.044, subdivision 1, must provide an attestation with the notarized
25.14 signature of the applicant or authorized agent stating whether the applicant or authorized
25.15 agent received from an unaffiliated business or consultant any assistance preparing:

25.16 (1) the licensure application;

25.17 (2) the renewal application;

25.18 (3) any documentation or written policies submitted with the licensure application;

25.19 (4) any documentation or written policies submitted with the renewal application; or

25.20 (5) any documentation or written policies maintained as a requirement of licensure or
25.21 enrollment as a medical assistance provider.

25.22 Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 7, is amended
25.23 to read:

25.24 Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that
25.25 the program complies with all applicable rules and laws, the commissioner shall issue a
25.26 license consistent with this section or, if applicable, a temporary change of ownership license
25.27 under section 245A.043. At minimum, the license shall state:

25.28 (1) the name of the license holder;

25.29 (2) the address of the program;

25.30 (3) the effective date and expiration date of the license;

26.1 (4) the type of license and the specific service the license holder is licensed to provide;
26.2 (5) the maximum number and ages of persons that may receive services from the program;
26.3 and

26.4 (6) any special conditions of licensure.

26.5 (b) The commissioner may issue a license for a period not to exceed two years if:

26.6 (1) the commissioner is unable to conduct the observation required by subdivision 4,
26.7 paragraph (a), clause (3), because the program is not yet operational;

26.8 (2) certain records and documents are not available because persons are not yet receiving
26.9 services from the program; and

26.10 (3) the applicant complies with applicable laws and rules in all other respects.

26.11 (c) A decision by the commissioner to issue a license does not guarantee that any person
26.12 or persons will be placed or cared for in the licensed program.

26.13 (d) Except as provided in paragraphs (i) and (j), the commissioner shall not issue a
26.14 license if the applicant, license holder, or an affiliated controlling individual has:

26.15 (1) been disqualified and the disqualification was not set aside and no variance has been
26.16 granted;

26.17 (2) been denied a license under this chapter or chapter 142B within the past two years;

26.18 (3) had a license issued under this chapter or chapter 142B revoked within the past five
26.19 years; or

26.20 (4) failed to submit the information required of an applicant under subdivision 1,
26.21 paragraph (f), (g), ~~or (h)~~, or (j), after being requested by the commissioner.

26.22 When a license issued under this chapter or chapter 142B is revoked, the license holder
26.23 and each affiliated controlling individual with a revoked license may not hold any license
26.24 under chapter 245A for five years following the revocation, and other licenses held by the
26.25 applicant or license holder or licenses affiliated with each controlling individual shall also
26.26 be revoked.

26.27 (e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license
26.28 affiliated with a license holder or controlling individual that had a license revoked within
26.29 the past five years if the commissioner determines that (1) the license holder or controlling
26.30 individual is operating the program in substantial compliance with applicable laws and rules

27.1 and (2) the program's continued operation is in the best interests of the community being
27.2 served.

27.3 (f) Notwithstanding paragraph (d), the commissioner may issue a new license in response
27.4 to an application that is affiliated with an applicant, license holder, or controlling individual
27.5 that had an application denied within the past two years or a license revoked within the past
27.6 five years if the commissioner determines that (1) the applicant or controlling individual
27.7 has operated one or more programs in substantial compliance with applicable laws and rules
27.8 and (2) the program's operation would be in the best interests of the community to be served.

27.9 (g) In determining whether a program's operation would be in the best interests of the
27.10 community to be served, the commissioner shall consider factors such as the number of
27.11 persons served, the availability of alternative services available in the surrounding
27.12 community, the management structure of the program, whether the program provides
27.13 culturally specific services, and other relevant factors.

27.14 (h) The commissioner shall not issue or reissue a license under this chapter if an individual
27.15 living in the household where the services will be provided as specified under section
27.16 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside
27.17 and no variance has been granted.

27.18 (i) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued
27.19 under this chapter has been suspended or revoked and the suspension or revocation is under
27.20 appeal, the program may continue to operate pending a final order from the commissioner.
27.21 If the license under suspension or revocation will expire before a final order is issued, a
27.22 temporary provisional license may be issued provided any applicable license fee is paid
27.23 before the temporary provisional license is issued.

27.24 (j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of
27.25 a controlling individual or license holder, and the controlling individual or license holder
27.26 is ordered under section 245C.17 to be immediately removed from direct contact with
27.27 persons receiving services or is ordered to be under continuous, direct supervision when
27.28 providing direct contact services, the program may continue to operate only if the program
27.29 complies with the order and submits documentation demonstrating compliance with the
27.30 order. If the disqualified individual fails to submit a timely request for reconsideration, or
27.31 if the disqualification is not set aside and no variance is granted, the order to immediately
27.32 remove the individual from direct contact or to be under continuous, direct supervision
27.33 remains in effect pending the outcome of a hearing and final order from the commissioner.

(k) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must comply with the requirements in section 245A.10 and be reissued a new license to operate the program or the program must not be operated after the expiration date. Adult foster care, family adult day services, child foster residence setting, and community residential services license holders must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

(l) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a Tribal licensing authority has established jurisdiction to license the program or service.

(m) The commissioner of human services may coordinate and share data with the commissioner of children, youth, and families to enforce this section.

(n) For substance use disorder treatment programs, for the purposes of paragraph (a), clause (5), the maximum number of persons who may receive services from the program includes persons served at satellite locations.

Sec. 9. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision to read:

Subd. 7. Department of Human Services home and community-based services early and often licensor and compliance team. (a) The commissioner must establish and maintain a home and community-based services early and often licensor and compliance team to deliver proactive and coordinated support to applicants through the application process and to license holders during the first year of operation of the licensed home and community-based program. The commissioner must ensure that the home and community-based services early and often licensor and compliance team has sufficient staff and resources to perform the functions required under this subdivision. The commissioner must ensure that the licensor and compliance team has members with expertise in licensing requirements and members with expertise in medical assistance enrollment requirements, medical assistance service delivery requirements, and medical assistance billing requirements.

(b) The home and community-based services early and often licensor and compliance team must provide technical assistance to applicants regarding completing and submitting license applications under this chapter and chapter 256D and medical assistance provider enrollment applications under section 256B.04, subdivision 21.

(c) The home and community-based services early and often licensor and compliance team must conduct an initial scheduled technical assistance visit three months after the effective date of an initial license for the purpose of providing technical assistance to the license holder. The team must provide technical assistance related to achieving and maintaining compliance with the applicable laws, rules, and regulations governing the provision of and reimbursement for home and community-based services under this chapter and chapters 245D, 256B, and 256S and waiver plans.

(d) The home and community-based services early and often licensor and compliance team must conduct three unscheduled visits after the beginning of the sixth calendar month following the effective date of an initial license and before the end of the eighteenth month following the effective date of an initial license.

(e) If during the technical assistance visit or during the following three unannounced visits, the team finds that the license holder has failed to achieve compliance with an applicable law, rule, or regulation, and the failure does not imminently endanger the health, safety, or rights of persons served by the program, the team may issue a licensing and compliance review report with recommendations for achieving and maintaining compliance.

(f) Nothing in this subdivision shall be construed to limit the commissioner's authority to:

(1) suspend or revoke a license or issue a fine at any time under section 245A.07 or issue correction orders and make a license conditional for failure to comply with applicable laws, rules, or regulations under section 245A.06 based on the nature, chronicity, or severity of the violation of a law, rule, or regulation and the effect of the violation on the health, safety, or rights of persons served by the program; or

(2) impose a sanction under section 256B.064 based on the nature, chronicity, or severity of the violation of law, rule, or regulation.

Sec. 10. Minnesota Statutes 2025 Supplement, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

(a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

(2) fails to comply with applicable laws or rules;

30.1 (3) knowingly withholds relevant information from or gives false or misleading
30.2 information to the commissioner in connection with an application for a license or during
30.3 an investigation;

30.4 (4) has a disqualification that has not been set aside under section 245C.22 and no
30.5 variance has been granted;

30.6 (5) has an individual living in the household who received a background study under
30.7 section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that
30.8 has not been set aside under section 245C.22, and no variance has been granted;

30.9 (6) is associated with an individual who received a background study under section
30.10 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
30.11 children or vulnerable adults, and who has a disqualification that has not been set aside
30.12 under section 245C.22, and no variance has been granted;

30.13 (7) fails to comply with section 245A.04, subdivision 1, paragraph (f) ~~or~~ (g), or (j);

30.14 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
30.15 6;

30.16 (9) has a history of noncompliance as a license holder or controlling individual with
30.17 applicable laws or rules, including but not limited to this chapter and chapters 142E and
30.18 245C;

30.19 (10) is prohibited from holding a license according to section 245.095; or

30.20 (11) is the subject of a pending administrative, civil, or criminal investigation.

30.21 (b) An applicant whose application has been denied by the commissioner must be given
30.22 notice of the denial, which must state the reasons for the denial in plain language. Notice
30.23 must be given by certified mail, by personal service, or through the provider licensing and
30.24 reporting hub. The notice must state the reasons the application was denied and must inform
30.25 the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules,
30.26 parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the
30.27 commissioner in writing by certified mail, by personal service, or through the provider
30.28 licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the
30.29 commissioner within 20 calendar days after the applicant received the notice of denial. If
30.30 an appeal request is made by personal service, it must be received by the commissioner
30.31 within 20 calendar days after the applicant received the notice of denial. If the order is issued
30.32 through the provider hub, the appeal must be received by the commissioner within 20

31.1 calendar days from the date the commissioner issued the order through the hub. Section
31.2 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

31.3 Sec. 11. Minnesota Statutes 2024, section 245D.081, subdivision 3, is amended to read:

31.4 Subd. 3. **Program management and oversight.** (a) The license holder must designate
31.5 a managerial staff person or persons to provide program management and oversight of the
31.6 services provided by the license holder. The designated manager is responsible for the
31.7 following:

31.8 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
31.9 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
31.10 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~
31.11 256B.044, subdivision 8;

31.12 (2) ensuring the duties of the designated coordinator are fulfilled according to the
31.13 requirements in subdivision 2;

31.14 (3) ensuring the program implements corrective action identified as necessary by the
31.15 program following review of incident and emergency reports according to the requirements
31.16 in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of
31.17 alleged or suspected maltreatment must be conducted according to the requirements in
31.18 section 245A.65, subdivision 1, paragraph (b);

31.19 (4) evaluation of satisfaction of persons served by the program, the person's legal
31.20 representative, if any, and the case manager, with the service delivery and progress toward
31.21 accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and
31.22 protecting each person's rights as identified in section 245D.04;

31.23 (5) ensuring staff competency requirements are met according to the requirements in
31.24 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
31.25 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

31.26 (6) ensuring corrective action is taken when ordered by the commissioner and that the
31.27 terms and conditions of the license and any variances are met; and

31.28 (7) evaluating the information identified in clauses (1) to (6) to develop, document, and
31.29 implement ongoing program improvements.

31.30 (b) The designated manager must be competent to perform the duties as required and
31.31 must minimally meet the education and training requirements identified in subdivision 2,

32.1 paragraph (b), and have a minimum of three years of supervisory level experience in a
32.2 program that provides care or education to vulnerable adults or children.

32.3 Sec. 12. Minnesota Statutes 2025 Supplement, section 256.01, subdivision 2, is amended
32.4 to read:

32.5 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2,
32.6 the commissioner of human services shall carry out the specific duties in paragraphs (a)
32.7 through (z):

32.8 (a) Administer and supervise the forms of public assistance provided for by state law
32.9 and other welfare activities or services that are vested in the commissioner. Administration
32.10 and supervision of human services activities or services includes, but is not limited to,
32.11 assuring timely and accurate distribution of benefits, completeness of service, and quality
32.12 program management. In addition to administering and supervising human services activities
32.13 vested by law in the department, the commissioner shall have the authority to:

32.14 (1) require county agency participation in training and technical assistance programs to
32.15 promote compliance with statutes, rules, federal laws, regulations, and policies governing
32.16 human services;

32.17 (2) monitor, on an ongoing basis, the performance of county agencies in the operation
32.18 and administration of human services, enforce compliance with statutes, rules, federal laws,
32.19 regulations, and policies governing welfare services and promote excellence of administration
32.20 and program operation;

32.21 (3) develop a quality control program or other monitoring program to review county
32.22 performance and accuracy of benefit determinations;

32.23 (4) require county agencies to make an adjustment to the public assistance benefits issued
32.24 to any individual consistent with federal law and regulation and state law and rule and to
32.25 issue or recover benefits as appropriate;

32.26 (5) delay or deny payment of all or part of the state and federal share of benefits and
32.27 administrative reimbursement according to the procedures set forth in section 256.017;

32.28 (6) make contracts with and grants to public and private agencies and organizations,
32.29 both profit and nonprofit, and individuals, using appropriated funds; and

32.30 (7) enter into contractual agreements with federally recognized Indian Tribes with a
32.31 reservation in Minnesota to the extent necessary for the Tribe to operate a federally approved
32.32 family assistance program or any other program under the supervision of the commissioner.

33.1 The commissioner shall consult with the affected county or counties in the contractual
33.2 agreement negotiations, if the county or counties wish to be included, in order to avoid the
33.3 duplication of county and Tribal assistance program services. The commissioner may
33.4 establish necessary accounts for the purposes of receiving and disbursing funds as necessary
33.5 for the operation of the programs.

33.6 The commissioner shall work in conjunction with the commissioner of children, youth, and
33.7 families to carry out the duties of this paragraph when necessary and feasible.

33.8 (b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law,
33.9 regulation, and policy necessary to county agency administration of the programs.

33.10 (c) Administer and supervise all noninstitutional service to persons with disabilities,
33.11 including persons who have vision impairments, and persons who are deaf, deafblind, and
33.12 hard-of-hearing or with other disabilities. The commissioner may provide and contract for
33.13 the care and treatment of qualified indigent children in facilities other than those located
33.14 and available at state hospitals operated by the executive board when it is not feasible to
33.15 provide the service in state hospitals operated by the executive board.

33.16 (d) Assist and actively cooperate with other departments, agencies and institutions, local,
33.17 state, and federal, by performing services in conformity with the purposes of Laws 1939,
33.18 chapter 431.

33.19 (e) Act as the agent of and cooperate with the federal government in matters of mutual
33.20 concern relative to and in conformity with the provisions of Laws 1939, chapter 431,
33.21 including the administration of any federal funds granted to the state to aid in the performance
33.22 of any functions of the commissioner as specified in Laws 1939, chapter 431, and including
33.23 the promulgation of rules making uniformly available medical care benefits to all recipients
33.24 of public assistance, at such times as the federal government increases its participation in
33.25 assistance expenditures for medical care to recipients of public assistance, the cost thereof
33.26 to be borne in the same proportion as are grants of aid to said recipients.

33.27 (f) Establish and maintain any administrative units reasonably necessary for the
33.28 performance of administrative functions common to all divisions of the department.

33.29 (g) Act as designated guardian of both the estate and the person of all the wards of the
33.30 state of Minnesota, whether by operation of law or by an order of court, without any further
33.31 act or proceeding whatever, except as to persons committed as developmentally disabled.

33.32 (h) Act as coordinating referral and informational center on requests for service for
33.33 newly arrived immigrants coming to Minnesota.

(i) The specific enumeration of powers and duties as hereinabove set forth shall in no way be construed to be a limitation upon the general transfer of powers herein contained.

(j) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital, nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

(k) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(1) the United States Secretary of Health and Human Services has agreed, for the same project, to waive state plan requirements relative to statewide uniformity; and

(2) a comprehensive plan, including estimated project costs, shall be approved by the Legislative Advisory Commission and filed with the commissioner of administration.

(l) According to federal requirements and in coordination with the commissioner of children, youth, and families, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(m) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for medical assistance in the following manner:

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. Disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for medical assistance. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

(2) notwithstanding the provisions of clause (1), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in clause (1), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to clause (1).

(n) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches \$1,000,000. When the balance in the account exceeds \$1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(o) Have the authority to establish and enforce the following county reporting requirements:

(1) the commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced;

(2) the county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner;

(3) if the required reports are not received by the deadlines established in clause (2), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received;

(4) a county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance;

(5) the final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period;

(6) the commissioner may not delay payments, withhold funds, or require repayment under clause (3) or (5) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under clause (3) or (5), the county board may appeal the action according to sections 14.57 to 14.69; and

(7) counties subject to withholding of funds under clause (3) or forfeiture or repayment of funds under clause (5) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under clause (3) or (5).

(p) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample in direct proportion to each county's claim for that period.

(q) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department, including but not limited to a preenrollment risk assessment. A preenrollment risk assessment under this paragraph must be conducted in accordance with the procedures and criteria established in section 256B.0437.

(r) Require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the department.

37.1 (s) Have the authority to administer the federal drug rebate program for drugs purchased
37.2 under the medical assistance program as allowed by section 1927 of title XIX of the Social
37.3 Security Act and according to the terms and conditions of section 1927. Rebates shall be
37.4 collected for all drugs that have been dispensed or administered in an outpatient setting and
37.5 that are from manufacturers who have signed a rebate agreement with the United States
37.6 Department of Health and Human Services.

37.7 (t) Have the authority to administer a supplemental drug rebate program for drugs
37.8 purchased under the medical assistance program. The commissioner may enter into
37.9 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
37.10 authorization for drugs that are from manufacturers that have not signed a supplemental
37.11 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
37.12 256B.0625, subdivision 13.

37.13 (u) Operate the department's communication systems account established in Laws 1993,
37.14 First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
37.15 communication costs necessary for the operation of the programs the commissioner
37.16 supervises. Each account must be used to manage shared communication costs necessary
37.17 for the operations of the programs the commissioner supervises. The commissioner may
37.18 distribute the costs of operating and maintaining communication systems to participants in
37.19 a manner that reflects actual usage. Costs may include acquisition, licensing, insurance,
37.20 maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit
37.21 organizations and state, county, and local government agencies involved in the operation
37.22 of programs the commissioner supervises may participate in the use of the department's
37.23 communications technology and share in the cost of operation. The commissioner may
37.24 accept on behalf of the state any gift, bequest, devise or personal property of any kind, or
37.25 money tendered to the state for any lawful purpose pertaining to the communication activities
37.26 of the department. Any money received for this purpose must be deposited in the department's
37.27 communication systems accounts. Money collected by the commissioner for the use of
37.28 communication systems must be deposited in the state communication systems account and
37.29 is appropriated to the commissioner for purposes of this section.

37.30 (v) Receive any federal matching money that is made available through the medical
37.31 assistance program for the consumer satisfaction survey. Any federal money received for
37.32 the survey is appropriated to the commissioner for this purpose. The commissioner may
37.33 expend the federal money received for the consumer satisfaction survey in either year of
37.34 the biennium.

(w) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated to the commissioner and all designated information and referral centers shall receive payments according to normal department schedules established by the commissioner upon final approval of allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

(x) Develop recommended standards for adult foster care homes that address the components of specialized therapeutic services to be provided by adult foster care homes with those services.

(y) Authorize the method of payment to or from the department as part of the human services programs administered by the department. This authorization includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the human services programs administered by the department.

(z) Designate the agencies that operate the Senior LinkAge Line under section 256.975, subdivision 7, and the Disability Hub under subdivision 24 as the state of Minnesota Aging and Disability Resource Center under United States Code, title 42, section 3001, the Older Americans Act Amendments of 2006, and incorporate cost reimbursement claims from the designated centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement must be appropriated to the commissioner and treated consistent with section 256.011. All Aging and Disability Resource Center designated agencies shall receive payments of grant funding that supports the activity and generates the federal financial participation according to Board on Aging administrative granting mechanisms.

Sec. 13. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 46. Department of Human Services home and community-based services provider support and technical assistance team. The commissioner must establish and maintain a home and community-based services provider support and technical assistance

39.1 team to deliver proactive and coordinated support to home and community-based services
 39.2 providers. The commissioner must ensure that the home and community-based services
 39.3 provider support and technical assistance team has sufficient staff and resources to perform
 39.4 the functions required under this subdivision. The home and community-based services
 39.5 provider support and technical assistance team must:

39.6 (1) serve as a provider liaison and help desk for providers' technical, regulatory, and
 39.7 operational questions;

39.8 (2) develop training and onboarding materials for home and community-based services
 39.9 providers;

39.10 (3) collect data on home and community-based provider challenges;

39.11 (4) coordinate the functions of the department, including information technology,
 39.12 licensing, provider enrollment, service delivery oversight, and program integrity oversight
 39.13 to clarify program requirements, provider requirements, and service requirements and to
 39.14 support providers with compliance and prevention of fraud; and

39.15 (5) make recommendations to the commissioner regarding changes to the operations of
 39.16 the department or to the design and implementation of home and community-based services
 39.17 that would improve the delivery of services and improve program integrity.

39.18 Sec. 14. Minnesota Statutes 2024, section 256B.04, subdivision 5, is amended to read:

39.19 Subd. 5. **Annual report required.** The state agency within 60 days after the close of
 39.20 each fiscal year, shall prepare and print for the fiscal year a report that includes: a full
 39.21 account of the operations and expenditure of funds under this chapter; a full account of the
 39.22 activities undertaken in accordance with subdivision 10; adequate and complete statistics
 39.23 divided by counties about all medical assistance provided in accordance with this chapter;
 39.24 a full account of all pre-enrollment, postenrollment, and unannounced site visits to providers
 39.25 under section 256B.044, subdivision 5; and any other information it may deem advisable.

39.26 Sec. 15. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, as amended
 39.27 by Laws 2026, chapter 95, article 4, section 12, is amended to read:

39.28 Subd. 21. **Provider enrollment.** ~~(a) The commissioner shall enroll providers and conduct~~
 39.29 ~~screening activities as required by Code of Federal Regulations, title 42, section 455, subpart~~
 39.30 ~~E, and sections 256B.044 to 256B.0448. A provider must enroll each provider-controlled~~
 39.31 ~~location where direct services are provided. The commissioner may deny a provider's~~
 39.32 ~~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:~~

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

~~(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~~

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

43.3 ~~(2) At the time of initial enrollment or reenrollment, durable medical equipment providers~~
43.4 ~~and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating~~
43.5 ~~provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,~~
43.6 ~~the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's~~
43.7 ~~Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must~~
43.8 ~~purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and~~
43.9 ~~fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions~~
43.10 ~~from a surety bond must occur within six years from the date the debt is affirmed by a final~~
43.11 ~~agency decision. An agency decision is final when the right to appeal the debt has been~~
43.12 ~~exhausted or the time to appeal has expired under section 256B.064.~~

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

43.17 ~~(m) The Department of Human Services may require a provider to purchase a surety~~
43.18 ~~bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment~~
43.19 ~~if: (1) the provider fails to demonstrate financial viability, (2) the department determines~~
43.20 ~~there is significant evidence of or potential for fraud and abuse by the provider, or (3) the~~
43.21 ~~provider or category of providers is designated high-risk pursuant to paragraph (f) and as~~
43.22 ~~per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an~~
43.23 ~~amount of \$100,000 or ten percent of the provider's payments from Medicaid during the~~
43.24 ~~immediately preceding 12 months, whichever is greater. The surety bond must name the~~
43.25 ~~Department of Human Services as an obligee and must allow for recovery of costs and fees~~
43.26 ~~in pursuing a claim on the bond. This paragraph does not apply if the provider currently~~
43.27 ~~maintains a surety bond under the requirements in section 256B.0659, 256B.0701, or~~
43.28 ~~256B.85.~~

43.29 Sec. 16. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision
43.30 to read:

43.31 Subd. 28. Medical assistance education program. (a) The commissioner must provide
43.32 information to all medical assistance enrollees on the following topics:

43.33 (1) an enrollee's benefits, rights, and responsibilities under medical assistance;

44.1 (2) how to appropriately access and receive services under medical assistance;

44.2 (3) an enrollee's right to file complaints, grievances, and appeals;

44.3 (4) general information about preventing fraud and abuse in the medical assistance

44.4 program; and

44.5 (5) how to report concerns to the department and managed care organizations about

44.6 fraud and abuse in the medical assistance program.

44.7 (b) The commissioner must ensure that the information provided under this subdivision:

44.8 (1) is in plain language;

44.9 (2) is culturally and linguistically appropriate; and

44.10 (3) complies with applicable federal Medicaid requirements for communicating with

44.11 enrollees.

44.12 (c) When an enrollee's use of medical assistance results in abusive or fraudulent billing,

44.13 the commissioner must notify the enrollee about the availability of the information under

44.14 this subdivision and may provide additional educational information targeted to the event

44.15 that resulted in abusive or fraudulent billing.

44.16 (d) The commissioner may require entities participating in medical assistance, including

44.17 but not limited to managed care organizations, providers, lead agencies, and Tribal agencies,

44.18 to assist in delivering the information required under this subdivision.

44.19 (e) For enrollees who receive case management services or have a support plan developed

44.20 under section 256B.0911, the information required under this subdivision must be tailored

44.21 to their service needs and may be delivered through the support planning process by the

44.22 lead agency or managed care organization, as appropriate.

44.23 **Sec. 17. [256B.0437] PREENROLLMENT ASSESSMENT.**

44.24 (a) Before enrolling a provider or agency, the commissioner may complete a

44.25 preenrollment risk assessment of the provider or agency seeking to enroll to confirm the

44.26 provider or agency's eligibility and the provider or agency's ability to meet the requirements

44.27 of this chapter. The commissioner must utilize a risk-score framework as a component of

44.28 the assessment that identifies service-specific fraud risk indicators, including but not limited

44.29 to organizational readiness, financial stability, compliance history, and addressing service

44.30 necessity.

(b) Based on the assessment of fraud risk indicators described in paragraph (a), the commissioner may deem the applicant ineligible and deny or rescind enrollment. The decision to deny or rescind enrollment must be made in writing and sent using a signature-verified confirmed delivery method. An applicant may request reconsideration of the decision regarding the applicant's eligibility in writing within 30 business days after the date the notice was issued. The commissioner must notify each applicant of the commissioner's final decision regarding the applicant's eligibility.

(c) A provider enrolled before July 1, 2026, that billed for services on or after January 1, 2025, must receive a positive preenrollment risk assessment no later than July 1, 2027, to remain eligible. A provider or agency enrolled before July 1, 2026, that has not billed for services on or after January 1, 2025, must receive a positive preenrollment risk assessment no later than July 1, 2026, to remain eligible. A provider that becomes ineligible under this paragraph regains eligibility after receiving a positive assessment under this section if the provider remains otherwise eligible.

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

Sec. 18. **[256B.044] PROVIDER ENROLLMENT.**

Subdivision 1. **Designating categorical risk levels.** (a) The commissioner must designate provider types as "limited-risk," "moderate-risk," 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 commissioner must publish a list of provider types and designated categorical risk levels in the Minnesota Health Care Program Provider Manual.

(b) The list and criteria are not subject to the requirements under chapter 14 and section 14.386 does not apply.

(c) The commissioner's designations are not subject to administrative appeal.

Subd. 2. **Required verifications and checks.** The commissioner must perform the following verifications and checks prior to making an enrollment determination and periodically thereafter:

(1) verify that the provider meets applicable federal and state requirements for the provider type;

(2) conduct license verifications, as applicable, including verification of current licensure in Minnesota and in any other state in which the provider is or was previously licensed, in accordance with Code of Federal Regulations, title 42, section 455.412;

(3) conduct database checks on a pre-enrollment and postenrollment basis to ensure that the provider continues to meet the enrollment criteria for the provider type, in accordance with Code of Federal Regulations, title 42, section 455.436;

(4) confirm that the provider and any disclosed owners, managing employees, or controlling individuals are not excluded from participation in any state's Medicaid program, Medicare, or any other federal health care program;

(5) verify the provider's National Provider Identifier and, as applicable, Medicare enrollment status;

(6) verify the provider's tax identification number and business registration status;

(7) verify the provider's ownership and control disclosures as required under federal law; and

(8) conduct any additional screenings, verifications, or reviews that are necessary to protect the integrity of the medical assistance program or that are required under federal law.

Subd. 3. **Required background studies.** (a) The commissioner must conduct a background study under chapter 245C for a provider applying for enrollment. The background study must include a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), and any other databases required under federal law.

(b) The commissioner must conduct a background study under this subdivision for each individual with an ownership or control interest in, or who is an officer, director, agent, managing employee, or other person with operational or managerial control of, the provider.

(c) Fingerprint-based studies are required when mandated by federal law or when a provider is designated moderate-risk or high-risk under subdivision 1.

(d) The commissioner may conduct background studies postenrollment as necessary.

(e) A provider's failure to submit to the commissioner the information required for a background study under this subdivision is grounds for denial or termination of enrollment in medical assistance.

(f) A provider's enrollment must be denied or terminated if a provider or individual subject to a background study under this subdivision is disqualified under chapter 245C or is excluded from participating in any federal health care programs.

47.1 Subd. 4. **Service location enrollment.** (a) A provider must enroll each provider-controlled
47.2 location where direct services are provided. "Provider-controlled location" means a physical
47.3 site owned, leased, operated, or otherwise controlled by the provider.

47.4 (b) Separate enrollment is not required for services provided in a recipient's home or
47.5 community setting, telehealth services delivered from an enrolled site, compliant mobile
47.6 services, or other federally permissible exemptions.

47.7 (c) A provider's failure to enroll each provider-controlled location where direct services
47.8 are provided is grounds for sanctions under section 256B.064.

47.9 Subd. 5. **Required on-site inspections.** (a) As a condition of enrollment in medical
47.10 assistance, the commissioner shall require that a provider designated as moderate-risk or
47.11 high-risk by CMS or the commissioner permit CMS, CMS's agents, or CMS's designated
47.12 contractors and the state agency, the state agency's agents, or the state agency's designated
47.13 contractors to conduct unannounced on-site inspections of any provider location.

47.14 (b) Consistent with the commissioner's authority under Code of Federal Regulations,
47.15 title 42, section 455.452, prior to enrolling, prior to reenrolling, and prior to revalidating a
47.16 provider designated as moderate-risk or high-risk, the commissioner must conduct
47.17 unannounced on-site inspections of all provider locations.

47.18 Subd. 6. **Surety bonds.** (a) The commissioner must require a provider to purchase a
47.19 surety bond as a condition of initial enrollment, reenrollment, revalidation, reinstatement,
47.20 or continued enrollment. Upon new enrollment, or if the provider's medical assistance
47.21 revenue in the previous calendar year is less than or equal to \$300,000, the provider must
47.22 purchase a surety bond of \$50,000. If the provider's medical assistance revenue in the
47.23 previous calendar year is greater than \$300,000, the provider must purchase a surety bond
47.24 of \$100,000. The surety bond must name the Department of Human Services as an obligee,
47.25 must be purchased new annually, and must allow for recovery of costs and fees in pursuing
47.26 a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety
47.27 bond must occur within six years from the date the debt is affirmed by a final agency
47.28 decision. An agency decision is final when the right to appeal the debt has been exhausted
47.29 or the time to appeal has expired under section 256B.064.

47.30 (b) This subdivision does not apply if the provider currently maintains a surety bond
47.31 under the requirements under section 256B.0659, 256B.0701, or 256B.85.

47.32 Subd. 7. **Financial capacity.** As a condition of enrolling in medical assistance, the
47.33 commissioner must require, in a form and manner prescribed by the commissioner, that a
47.34 provider attest to sufficient financial capacity to operate.

48.1 Subd. 8. **Compliance programs.** (a) The commissioner may require, as a condition of
48.2 enrollment in medical assistance, that a provider in a particular industry, of a particular
48.3 provider type, or with a particular risk categorization under subdivision 1, establish and
48.4 maintain a compliance program consistent with federal program integrity guidance issued
48.5 by CMS or the United States Department of Health and Human Services Office of Inspector
48.6 General.

48.7 (b) If an enrolled provider is required by the commissioner or by federal or state law to
48.8 designate an individual as the provider's compliance officer, the provider must appoint an
48.9 individual responsible for implementing and overseeing the compliance program.

48.10 (c) At a minimum, the compliance program must include policies and procedures designed
48.11 to:

48.12 (1) ensure adherence to federal and state laws and program requirements governing
48.13 medical assistance and prevent the submission of improper claims;

48.14 (2) train employees, agents, contractors, and subcontractors, including billing personnel,
48.15 on applicable federal and state laws and program requirements;

48.16 (3) establish procedures for receiving, investigating, and responding to allegations of
48.17 improper conduct and for implementing corrective actions;

48.18 (4) use auditing, monitoring, or other evaluation techniques to assess ongoing compliance;

48.19 (5) promptly report to the commissioner any credible evidence of violations of federal
48.20 and state laws or regulations governing medical assistance; and

48.21 (6) report and return identified medical assistance overpayments within 60 days after
48.22 discovery or by the date any corresponding cost report is due, whichever is later, in
48.23 accordance with federal law.

48.24 Subd. 9. **Incomplete provider enrollment applications.** The commissioner may deny
48.25 a provider's incomplete enrollment application if a provider fails to respond to the
48.26 commissioner's request for additional information within 60 days of the request.

48.27 Subd. 10. **Correspondence and notification.** The commissioner may deliver
48.28 correspondence and notifications, including notifications of termination and other actions,
48.29 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to
48.30 correspondence and notifications related to background studies.

Sec. 19. [256B.0441] PROVIDER REVALIDATION.

Subdivision 1. Requirement. The commissioner must revalidate each enrolled provider according to this section.

Subd. 2. Schedule. (a) The commissioner shall revalidate:

(1) each provider at least once every five years;

(2) each personal care assistance agency, community first services and supports (CFSS) provider-agency, and CFSS financial management services provider at least once every three years;

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

(4) each medical-assistance-only provider type the commissioner deems high-risk under section 256B.044, subdivision 1, at least every three years.

(b) The commissioner must conduct revalidation of a provider more frequently when required under federal law or when necessary to protect program integrity.

Subd. 3. Procedures. (a) The commissioner shall conduct revalidation as follows:

(1) provide 30 days' notice to the provider of the provider's revalidation due date, including instructions for revalidation, a list of materials the provider must submit, and a notice about the possibility of an unannounced site visit as required under paragraph (b);

(2) if a provider fails to submit all required materials or satisfy the requirements of paragraph (b) by the due date, notify the provider of the deficiency within 14 days after the due date and allow the provider an additional 14 days from the notification date to comply; and

(3) if a provider fails to remedy a deficiency within the additional 28-day time period, give 15 days' notice of termination and immediately suspend the provider's ability to bill. The commissioner's decision to suspend the provider's ability to bill is not subject to an administrative appeal.

(b) For a provider designated moderate-risk or high-risk, the commissioner must conduct unannounced site visits at each of the provider's enrolled locations under section 256B.044, subdivision 4, no more than 30 days prior to the provider's revalidation due date.

(c) A provider must demonstrate financial capacity, as described under section 256B.044, subdivision 7, as a requirement of revalidation under this subdivision.

Sec. 20. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND TERMINATIONS.**

Subdivision 1. Suspension of billing privileges. (a) 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.

(b) Notwithstanding any law to the contrary, the commissioner may immediately impose a suspension under this subdivision when necessary to protect public funds or ensure program integrity.

(c) A suspension under this subdivision does not limit the authority of the commissioner to issue any other sanction authorized under federal or state law.

(d) The commissioner's decision to suspend a provider's ability to bill is not subject to an administrative appeal.

Subd. 2. Revocation for lack of documentation. (a) 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 the 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.

(b) Nothing in this subdivision limits the authority of the commissioner to sanction a provider under section 256B.064.

Subd. 3. Mandatory denial or termination of enrollment. (a) The commissioner must terminate or deny the enrollment of a provider when:

(1) an individual with a five percent or greater direct or indirect ownership interest in the provider does not submit timely and accurate information and cooperate with the screening methods required under section 256B.044;

(2) an individual with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to the individual's involvement in Medicare, Medicaid, or the Children's Health Insurance Program in the last ten years, unless the commissioner determines that denial or termination of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing;

(3) the provider, or an individual with a five percent or greater direct or indirect ownership interest in the provider, was terminated from participation in Medicare on or after January 1, 2011, or under a Medicaid program or Children's Health Insurance Program of any other state, and is currently included in the termination database under Code of Federal Regulations, title 42, section 455.417, except as provided in paragraph (b);

(4) the provider, or an individual with a five percent or greater direct or indirect ownership interest in the provider, fails to submit timely or accurate information, unless the commissioner determines that termination or denial of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing;

(5) the provider, or an individual with a five percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner determined by the commissioner within 30 days of a request from the Centers for Medicare and Medicaid Services (CMS) or the commissioner, unless the commissioner determines that termination or denial of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing;

(6) the provider fails to permit access to provider locations for any site visits under section 256B.044, subdivision 5, unless the commissioner determines that termination or denial of enrollment is not in the best interests of the medical assistance program and the commissioner documents that determination in writing; or

(7) CMS or the commissioner determines that the provider has falsified any information provided on the application or cannot verify the identity of any provider applicant.

(b) The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under paragraph (a), clause (3), 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.

Subd. 4. **Termination for lack of submitted claims.** The commissioner may terminate the enrollment of an individual provider or an entity provider if the individual provider or entity provider has not submitted any claims in the previous 12 consecutive calendar months.

52.1 Sec. 21. **[256B.0443] PROVIDER PAYMENT WITHHOLDS.**

52.2 (a) If the commissioner or the Centers for Medicare and Medicaid Services designates
52.3 a provider type as high-risk under section 256B.044, subdivision 1, the commissioner may
52.4 withhold payment from providers within that category upon initial enrollment for a 90-day
52.5 period.

52.6 (b) The withholding for each provider must begin on the date of the first submission of
52.7 a claim.

52.8 Sec. 22. **[256B.0444] ENROLLMENT MORATORIUM FOR HIGH-RISK**
52.9 **PROVIDERS.**

52.10 Subdivision 1. **Provider enrollment moratorium.** (a) If the commissioner or the Centers
52.11 for Medicare and Medicaid Services (CMS) designates a provider type as high-risk under
52.12 section 256B.044, subdivision 1, the commissioner may issue a statewide or regional
52.13 enrollment moratorium and stop accepting and processing applications from providers
52.14 within that category within 30 days of the date of the designation or upon federal approval
52.15 of the moratorium, whichever is later. A moratorium issued under this section is effective
52.16 for a period of up to 24 months from the date the moratorium is issued.

52.17 (b) Before ending the moratorium under this section, the commissioner must revalidate
52.18 the enrollment of each provider within the affected category in accordance with the
52.19 revalidation procedures under section 256B.0441, subdivision 3.

52.20 Subd. 2. **Moratorium exceptions.** The commissioner may grant exceptions to a
52.21 moratorium issued under subdivision 1 and must make publicly available the processes and
52.22 criteria the commissioner will use to grant exceptions. The commissioner may grant an
52.23 exception if a county or Tribal agency submits a request for an exception to the commissioner.

52.24 Subd. 3. **Continued enrollment of new clients.** Nothing in this section prohibits an
52.25 enrolled provider subject to a moratorium under this section from enrolling new clients or
52.26 beneficiaries during the period of the enrollment moratorium.

52.27 Subd. 4. **Notice.** (a) At least ten days prior to issuing an enrollment moratorium under
52.28 this section, the commissioner must notify enrolled providers within the affected category
52.29 and the chairs and ranking minority members of the legislative committees with jurisdiction
52.30 over health and human services about the actions the commissioner plans to take under this
52.31 section. The notice must:

52.32 (1) include a list of provider types to which the moratorium applies;

(2) provide a general explanation for the basis of the high-risk designation; and

(3) identify the start dates and anticipated durations of the enrollment moratorium.

(b) Within 60 days of ending an enrollment moratorium under this section, the commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services about the results of the moratorium.

Sec. 23. [256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS FOR SPECIFIC PROVIDER TYPES.

Subdivision 1. **Durable medical equipment provider or supplier.** (a) For the purposes of this subdivision, "durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rent to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rent.

(b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable medical equipment provider or supplier definition in paragraph (a), operating in Minnesota, and receiving medical assistance money must purchase a surety bond that is annually renewed, designates the state agency as the obligee, and is submitted in a form approved by the commissioner. For purposes of this paragraph, 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.

(c) At the time of initial enrollment or reenrollment, durable medical equipment providers or suppliers as defined in paragraph (a) must purchase a surety bond of \$50,000. If a revalidating provider's medical assistance 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 medical assistance 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 be purchased new annually and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064.

54.1 Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled
54.2 provider that is licensed by the commissioner under chapter 245A must designate an
54.3 individual as the licensee's compliance officer under section 256B.044, subdivision 8,
54.4 paragraph (b).

54.5 Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that
54.6 is licensed by the commissioner of health as a home care provider under chapter 144A with
54.7 a home and community-based services designation under section 144A.484 on the home
54.8 care license, or as an assisted living facility under chapter 144G, must designate an individual
54.9 as the licensee's compliance officer under section 256B.044, subdivision 8, paragraph (b).

54.10 Sec. 24. **[256B.0446] ADDITIONAL PROVIDER ENROLLMENT TRAINING**
54.11 **REQUIREMENTS FOR HIGH-RISK PROVIDERS.**

54.12 Subdivision 1. **Applicability.** This section applies to any agency that provides a service
54.13 designated by the commissioner as high-risk under section 256B.044, subdivision 1. For
54.14 purposes of this section, "agency" means the legal entity that is applying to be or is enrolled
54.15 with Minnesota health care programs as a medical assistance provider according to Minnesota
54.16 Rules, part 9505.0195.

54.17 Subd. 2. **Mandatory compliance training.** (a) Effective January 1, 2027, before applying
54.18 for enrollment or reenrollment as a medical assistance provider, an agency applying to
54.19 provide services designated by the commissioner as high-risk under section 256B.044,
54.20 subdivision 1, must require all owners of the agency who are active in the day-to-day
54.21 management and operations of the agency and all managerial and supervisory employees
54.22 to complete compliance training. All individuals required to complete training under this
54.23 subdivision must repeat the training prior to the agency's revalidation as a medical assistance
54.24 provider.

54.25 (b) New owners active in day-to-day management and operations of the agency and new
54.26 managerial and supervisory employees of the agency must complete compliance training
54.27 under this subdivision within 30 calendar days of becoming an owner of or beginning
54.28 employment with the agency and prior to conducting any management or operations activities
54.29 for the agency. If an individual moves to another agency providing the same service and
54.30 serves in a similar ownership or employment capacity, the individual is not required to
54.31 repeat the training required under this subdivision. If the individual does not repeat the
54.32 compliance training, the individual must provide documentation to the agency that proves
54.33 that the individual completed the compliance training within the provider revalidation

55.1 schedule for the relevant provider type as determined by the commissioner under section
55.2 256B.0441, subdivisions 2 and 3.

55.3 (c) The commissioner must determine the format and content of the compliance training.
55.4 The training must include the following topics, adapted as necessary for each provider type
55.5 subject to the requirements of this subdivision:

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

55.7 (2) enrollment requirements;

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

55.9 (4) fair labor standards;

55.10 (5) workplace safety requirements; and

55.11 (6) recent changes in service requirements.

55.12 **Sec. 25. [256B.0447] ENHANCED PREPAYMENT REVIEW.**

55.13 Subdivision 1. **Purpose and authority.** The commissioner must conduct enhanced
55.14 prepayment review of submitted fee-for-service medical assistance claims to ensure
55.15 compliance with state and federal law and prevent improper payments.

55.16 Subd. 2. **Review requirement.** Beginning April 1, 2027, the commissioner must conduct
55.17 enhanced prepayment review under this section of at least 65 percent of all fee-for-service
55.18 claims.

55.19 Subd. 3. **Notice.** (a) Except as provided in paragraph (b), the commissioner must provide
55.20 written notice to a provider placed under enhanced prepayment review at least 15 days
55.21 before the review is implemented. The notice must include:

55.22 (1) the basis for the review;

55.23 (2) the effective date of the review; and

55.24 (3) the standards the commissioner will use to determine when the provider, covered
55.25 service, or claims will no longer be subject to enhanced prepayment review.

55.26 (b) The commissioner may delay, limit, or withhold notice to a provider if providing
55.27 notice would compromise program integrity, prejudice an audit or investigation, or conflict
55.28 with federal law or federal guidance.

55.29 Subd. 4. **Continued enrollment of new clients.** Nothing in this section prohibits an
55.30 enrolled provider that is subject to enhanced prepayment review from enrolling new clients

56.1 or beneficiaries during the period of review unless otherwise prohibited by law or by a
56.2 separate action of the commissioner.

56.3 Subd. 5. **Timely claims processing.** The commissioner must administer enhanced
56.4 prepayment review in a manner consistent with Code of Federal Regulations, title 42, section
56.5 447.45.

56.6 Subd. 6. **Relationship to other actions.** Enhanced prepayment review under this section
56.7 does not preclude the commissioner from conducting a preliminary investigation, full
56.8 investigation, payment suspension, postpayment review, audit, overpayment recovery,
56.9 sanction, or referral to law enforcement under this chapter or under applicable federal law.

56.10 Subd. 7. **Information on website.** At least annually, the commissioner must publish
56.11 information on enhanced prepayment review on the Department of Human Services website.
56.12 The information must include, at minimum, the list of covered services subject to review
56.13 and aggregate outcomes, including claim denials, payments delayed, and referrals for further
56.14 action.

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

56.16 Sec. 26. **[256B.0448] POSTPAYMENT REVIEW.**

56.17 Subdivision 1. **Purpose and authority.** The commissioner may conduct postpayment
56.18 review of claims, encounters, cost reports, rate submissions, and other billings submitted
56.19 for payment or reimbursement under this chapter to identify improper payments and recover
56.20 payments made in violation of state or federal law or program requirements.

56.21 Subd. 2. **Scope of review.** The commissioner may conduct postpayment review on a
56.22 claim-by-claim basis or through other review methods authorized by state or federal law.

56.23 Subd. 3. **Provider obligations.** (a) A provider subject to postpayment review must
56.24 maintain documentation necessary to support claims, encounters, cost reports, rate
56.25 submissions, other billings submitted for payment or reimbursement under this chapter, and
56.26 compliance with program requirements.

56.27 (b) The commissioner may require a provider to submit records or supporting
56.28 documentation relevant to a postpayment review.

56.29 (c) A provider's failure to provide requested records or supporting documentation to the
56.30 commissioner according to the timeline specified by the commissioner may result in recovery
56.31 of payments or sanctions under section 256B.064 and other applicable laws.

57.1 Subd. 4. **Recovery and sanctions.** If postpayment review identifies an overpayment or
57.2 other noncompliance with medical assistance payment requirements, the commissioner may
57.3 recover payments and impose sanctions in accordance with section 256B.064 and other
57.4 applicable laws.

57.5 Subd. 5. **Relationship to other actions.** Conducting postpayment review of a provider
57.6 under this section does not preclude the commissioner from conducting a preliminary
57.7 investigation, full investigation, enhanced prepayment review, payment suspension, audit,
57.8 overpayment recovery, sanction, or referral to law enforcement under this chapter or
57.9 applicable federal law.

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

57.11 Sec. 27. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is
57.12 amended to read:

57.13 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
57.14 means motor vehicle transportation provided by a public or private person that serves
57.15 Minnesota health care program beneficiaries who do not require emergency ambulance
57.16 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

57.17 (b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
57.18 a census-tract based classification system under which a geographical area is determined
57.19 to be urban, rural, or super rural. This paragraph expires ~~July 1, 2026, for medical assistance~~
57.20 ~~fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation
57.21 of the administrator under subdivision 18i.

57.22 (c) Medical assistance covers medical transportation costs incurred solely for obtaining
57.23 emergency medical care or transportation costs incurred by eligible persons in obtaining
57.24 emergency or nonemergency medical care when paid directly to an ambulance company,
57.25 nonemergency medical transportation company, or other recognized providers of
57.26 transportation services. Medical transportation must be provided by:

57.27 (1) nonemergency medical transportation providers who meet the requirements of this
57.28 subdivision;

57.29 (2) ambulances, as defined in section 144E.001, subdivision 2;

57.30 (3) taxicabs that meet the requirements of this subdivision;

57.31 (4) public transportation, within the meaning of "public transportation" as defined in
57.32 section 174.22, subdivision 7; or

58.1 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
58.2 subdivision 1, paragraph (p).

58.3 (d) Medical assistance covers nonemergency medical transportation provided by
58.4 nonemergency medical transportation providers enrolled in the Minnesota health care
58.5 programs. All nonemergency medical transportation providers must comply with the
58.6 operating standards for special transportation service as defined in sections 174.29 to 174.30
58.7 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
58.8 commissioner and reported on the claim as the individual who provided the service. All
58.9 nonemergency medical transportation providers shall bill for nonemergency medical
58.10 transportation services in accordance with Minnesota health care programs criteria. Publicly
58.11 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
58.12 requirements outlined in this paragraph.

58.13 (e) An organization may be terminated, denied, or suspended from enrollment if:

58.14 (1) the provider has not initiated background studies on the individuals specified in
58.15 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

58.16 (2) the provider has initiated background studies on the individuals specified in section
58.17 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

58.18 (i) the commissioner has sent the provider a notice that the individual has been
58.19 disqualified under section 245C.14; and

58.20 (ii) the individual has not received a disqualification set-aside specific to the special
58.21 transportation services provider under sections 245C.22 and 245C.23.

58.22 (f) The administrative agency of nonemergency medical transportation must:

58.23 (1) adhere to the policies defined by the commissioner;

58.24 (2) pay nonemergency medical transportation providers for services provided to
58.25 Minnesota health care programs beneficiaries to obtain covered medical services;

58.26 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
58.27 trips, and number of trips by mode; and

58.28 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
58.29 administrative structure assessment tool that meets the technical requirements established
58.30 by the commissioner, reconciles trip information with claims being submitted by providers,
58.31 and ensures prompt payment for nonemergency medical transportation services. This
58.32 paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027,~~

59.1 ~~for prepaid medical assistance~~ upon implementation of the administrator under subdivision
59.2 18i.

59.3 (g) ~~Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid~~
59.4 ~~medical assistance, upon implementation of the administrator under subdivision 18i,~~ the
59.5 administrative agency of nonemergency medical transportation must:

59.6 (1) adhere to the policies defined by the commissioner;

59.7 (2) pay nonemergency medical transportation providers for services provided to
59.8 Minnesota health care program beneficiaries to obtain covered medical services; and

59.9 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
59.10 trips, and number of trips by mode.

59.11 (h) Until the commissioner implements the single administrative structure and delivery
59.12 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
59.13 commissioner or an entity approved by the commissioner that does not dispatch rides for
59.14 clients using modes of transportation under paragraph (n), clauses (4), (5), (6), and (7). This
59.15 paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027,~~
59.16 ~~for prepaid medical assistance~~ upon implementation of the administrator under subdivision
59.17 18i.

59.18 (i) The commissioner may use an order by the recipient's attending physician, advanced
59.19 practice registered nurse, physician assistant, or a medical or mental health professional to
59.20 certify that the recipient requires nonemergency medical transportation services.

59.21 Nonemergency medical transportation providers shall perform driver-assisted services for
59.22 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
59.23 at and return to the individual's residence or place of business, assistance with admittance
59.24 of the individual to the medical facility, and assistance in passenger securement or in securing
59.25 of wheelchairs, child seats, or stretchers in the vehicle.

59.26 (j) Nonemergency medical transportation providers must take clients to the health care
59.27 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
59.28 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
59.29 authorization from the local agency. This paragraph expires ~~July 1, 2026, for medical~~
59.30 ~~assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon
59.31 implementation of the administrator under subdivision 18i.

59.32 (k) ~~Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,~~
59.33 ~~for prepaid medical assistance, upon implementation of the administrator under subdivision~~

18i, nonemergency medical transportation providers must take clients to the health care provider using the most direct route and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the administrator.

(l) Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(m) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(n) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety

61.1 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
61.2 the vehicle driver; and (ii) who is certified as a protected transport provider; and

61.3 (7) stretcher transport, which includes transport for a client in a prone or supine position
61.4 and requires a nonemergency medical transportation provider with a vehicle that can transport
61.5 a client in a prone or supine position.

61.6 (o) The local agency shall be the single administrative agency and shall administer and
61.7 reimburse for modes defined in paragraph (n) according to paragraphs (r) to (t) when the
61.8 commissioner has developed, made available, and funded the web-based single administrative
61.9 structure, assessment tool, and level of need assessment under subdivision 18e. The local
61.10 agency's financial obligation is limited to funds provided by the state or federal government.
61.11 This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1,~~
61.12 ~~2027, for prepaid medical assistance~~ upon implementation of the administrator under
61.13 subdivision 18i.

61.14 (p) The commissioner shall:

61.15 (1) verify that the mode and use of nonemergency medical transportation is appropriate;

61.16 (2) verify that the client is going to an approved medical appointment; and

61.17 (3) investigate all complaints and appeals.

61.18 (q) The administrative agency shall pay for the services provided in this subdivision and
61.19 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
61.20 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
61.21 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.
61.22 This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1,~~
61.23 ~~2027, for prepaid medical assistance~~ upon implementation of the administrator under
61.24 subdivision 18i.

61.25 (r) Payments for nonemergency medical transportation must be paid based on the client's
61.26 assessed mode under paragraph (m), not the type of vehicle used to provide the service. The
61.27 medical assistance reimbursement rates for nonemergency medical transportation services
61.28 that are payable by or on behalf of the commissioner for nonemergency medical
61.29 transportation services are:

61.30 (1) \$0.22 per mile for client reimbursement;

61.31 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
61.32 transport;

62.1 (3) equivalent to the standard fare for unassisted transport when provided by public
62.2 transit, and \$12.10 for the base rate and \$1.43 per mile when provided by a nonemergency
62.3 medical transportation provider;

62.4 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;

62.5 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;

62.6 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

62.7 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
62.8 an additional attendant if deemed medically necessary. This paragraph expires ~~July 1, 2026,~~
62.9 ~~for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~
62.10 upon implementation of the administrator under subdivision 18i.

62.11 (s) Effective ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027,~~
62.12 upon implementation of the administrator under subdivision 18i, for prepaid medical
62.13 assistance, payments for nonemergency medical transportation must be paid based on the
62.14 client's assessed mode under paragraph (m), not the type of vehicle used to provide the
62.15 service.

62.16 (t) The base rate for nonemergency medical transportation services in areas defined
62.17 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
62.18 paragraph (r), clauses (1) to (7). The mileage rate for nonemergency medical transportation
62.19 services in areas defined under RUCA to be rural or super rural areas is:

62.20 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
62.21 rate in paragraph (r), clauses (1) to (7); and

62.22 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
62.23 rate in paragraph (r), clauses (1) to (7). This paragraph expires ~~July 1, 2026, for medical~~
62.24 ~~assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon
62.25 implementation of the administrator under subdivision 18i.

62.26 (u) For purposes of reimbursement rates for nonemergency medical transportation
62.27 services under paragraphs (r) to (t), the zip code of the recipient's place of residence shall
62.28 determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph
62.29 expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid~~
62.30 ~~medical assistance~~ upon implementation of the administrator under subdivision 18i.

62.31 (v) The commissioner, when determining reimbursement rates for nonemergency medical
62.32 transportation, shall exempt all modes of transportation listed under paragraph (n) from
62.33 Minnesota Rules, part 9505.0445, item R, subitem (2).

(w) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds \$3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (r) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

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

Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 18i, is amended to read:

Subd. 18i. **Administration of nonemergency medical transportation.** (a) Effective July 1, 2026, ~~for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~, the commissioner must contract either statewide or regionally for the administration of the nonemergency medical transportation program in compliance with the provisions of this chapter. The contract must include the administration of the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

(b) The commissioner must provide six months notice to counties, managed care organizations, and county-based purchasing organizations before implementing the administrator required under this subdivision.

(c) The commissioner must notify the revisor of statutes when the administrator under this subdivision is implemented.

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

Sec. 29. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with serious mental illness. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the

64.1 Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900
64.2 to 9520.0926, and 9505.0322, excluding subpart 10.

64.3 ~~(b) Entities meeting program standards set out in rules governing family community~~
64.4 ~~support services as defined in section 245.4871, subdivision 17, are eligible for medical~~
64.5 ~~assistance reimbursement for case management services for children with serious mental~~
64.6 ~~illness when these services meet the program standards in Minnesota Rules, parts 9520.0900~~
64.7 ~~to 9520.0926 and 9505.0322, excluding subparts 6 and 10. To be eligible for medical~~
64.8 assistance reimbursement, an entity must document:

64.9 (1) face-to-face contacts between the case manager and the recipient;

64.10 (2) telephone contacts between the case manager and the recipient; the recipient's mental
64.11 health provider or other service providers; the recipient's family members, legal
64.12 representative, or primary caregiver; or other interested persons;

64.13 (3) face-to-face contacts between the case manager and the recipient's mental health
64.14 provider or other service providers; the recipient's family members, legal representative, or
64.15 primary caregiver; or other interested persons;

64.16 (4) contacts between the case manager and the case manager's clinical supervisor about
64.17 the recipient;

64.18 (5) individual community support plan and assessment development, review, and revision
64.19 required under section 245.4711, subdivision 4, for an adult, or section 245.4881, subdivision
64.20 4, for a child;

64.21 (6) travel time spent by the case manager to meet face-to-face with the recipient who
64.22 resides outside of the county of financial responsibility; and

64.23 (7) travel time spent by the case manager within the county of financial responsibility
64.24 to meet face-to-face with the recipient or the recipient's family, legal representative, or
64.25 primary caregiver.

64.26 (c) For purposes of paragraph (b), clauses (6) and (7), if a case manager arrives on time
64.27 for a scheduled face-to-face appointment with a recipient or the recipient's family member,
64.28 legal representative, or primary caregiver and the person fails to keep the appointment, the
64.29 time spent by the case manager traveling to and from the site of the scheduled appointment
64.30 is eligible for medical assistance payment. Provider entities must meet all program standards
64.31 set out in rules governing family community support services as defined in section 245.4871,
64.32 subdivision 17, and Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, subpart
64.33 9.

65.1 ~~(e)~~ (d) Medical assistance and MinnesotaCare payment for mental health case
65.2 management ~~shall~~ must be made ~~on a monthly basis~~ in accordance with section 256B.076,
65.3 subdivisions 1, 2, 5, and 6. ~~In order to receive payment for an eligible child, the provider~~
65.4 ~~must document at least a face-to-face contact either in person or by interactive video that~~
65.5 ~~meets the requirements of subdivision 20b with the child, the child's parents, or the child's~~
65.6 ~~legal representative. To receive payment for an eligible adult, the provider must document:~~

65.7 ~~(1) at least a face-to-face contact with the adult or the adult's legal representative either~~
65.8 ~~in person or by interactive video that meets the requirements of subdivision 20b; or~~

65.9 ~~(2) at least a telephone contact with the adult or the adult's legal representative and~~
65.10 ~~document a face-to-face contact either in person or by interactive video that meets the~~
65.11 ~~requirements of subdivision 20b with the adult or the adult's legal representative within the~~
65.12 ~~preceding two months.~~

65.13 ~~(d)~~ (e) Payment for mental health case management provided by county or state staff
65.14 ~~shall~~ must be based on the ~~monthly~~ rate methodology under section ~~256B.094, subdivision~~
65.15 ~~6, paragraph (b), with separate rates calculated for child welfare and mental health, and~~
65.16 ~~within mental health, separate rates for children and adults~~ 256B.076, subdivisions 5 and
65.17 7.

65.18 ~~(e)~~ (f) Payment for mental health case management provided by Indian health services
65.19 or by agencies operated by Indian tribes may be made according to this section or other
65.20 relevant federally approved rate setting methodology.

65.21 ~~(f)~~ (g) Payment for mental health case management provided by vendors who contract
65.22 with a county must be calculated in accordance with section 256B.076, subdivision 2.
65.23 Payment for mental health case management provided by vendors who contract with a Tribe
65.24 must be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate
65.25 charged by the vendor for the same service to other payers. If the service is provided by a
65.26 team of contracted vendors, the team shall determine how to distribute the rate among its
65.27 members. No reimbursement received by contracted vendors shall be returned to the county
65.28 or tribe, except to reimburse the county or tribe for advance funding provided by the county
65.29 or tribe to the vendor.

65.30 ~~(g)~~ (h) If the service is provided by a team which includes contracted vendors, tribal
65.31 staff, and county or state staff, the costs for county or state staff participation in the team
65.32 shall be included in the rate for county-provided services. In this case, the contracted vendor,
65.33 the tribal agency, and the county may each receive separate payment for services provided
65.34 by each entity in the same month. In order to prevent duplication of services, each entity

66.1 must document, in the recipient's file, the need for team case management and a description
66.2 of the roles of the team members.

66.3 ~~(h)~~ (i) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs
66.4 for mental health case management shall be provided by the recipient's county of
66.5 responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal
66.6 funds or funds used to match other federal funds. If the service is provided by a tribal agency,
66.7 the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is
66.8 paid by the state without a federal share through fee-for-service, 50 percent of the cost shall
66.9 be provided by the recipient's county of responsibility.

66.10 ~~(i)~~ (j) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
66.11 and MinnesotaCare include mental health case management. When the service is provided
66.12 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
66.13 share.

66.14 ~~(j)~~ (k) The commissioner may suspend, reduce, or terminate the reimbursement to a
66.15 provider that does not meet the ~~reporting or other~~ requirements of this section or section
66.16 245.4711, 245.4881, 256B.0924, 256B.094, or 256F.10. The county of responsibility, as
66.17 defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible
66.18 for any federal disallowances. The county or tribe may share this responsibility with its
66.19 contracted vendors.

66.20 ~~(k)~~ (l) The commissioner shall set aside a portion of the federal funds earned for county
66.21 expenditures under this section to repay the special revenue maximization account under
66.22 section 256.01, subdivision 2, paragraph (n). The repayment is limited to:

66.23 (1) the costs of developing and implementing this section; and

66.24 (2) programming the information systems.

66.25 ~~(l)~~ (m) Payments to counties and tribal agencies for case management expenditures under
66.26 this section shall only be made from federal earnings from services provided under this
66.27 section. When this service is paid by the state without a federal share through fee-for-service,
66.28 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
66.29 shall include the federal earnings, the state share, and the county share.

66.30 ~~(m)~~ (n) Case management services under this subdivision do not include therapy,
66.31 treatment, legal, or outreach services.

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

67.4 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
67.5 than six months in a calendar year; or

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

67.7 ~~(o)~~ (p) Payment for case management services under this subdivision shall not duplicate
67.8 payments made under other program authorities for the same purpose.

67.9 ~~(p)~~ (q) If the recipient is receiving care in a hospital, nursing facility, or residential setting
67.10 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
67.11 mental health targeted case management services must actively support identification of
67.12 community alternatives for the recipient and discharge planning.

67.13 (r) Counties may receive payment for up to 12 15-minute units for use at case initiation
67.14 and case closing to facilitate the recipient's needs assessments, individualized plan
67.15 development, referrals, or case documentation without needing to meet the contact
67.16 requirements specified under sections 245.4711, 245.4881, 256B.0924, 256B.094, and
67.17 256F.10.

67.18 Sec. 30. Minnesota Statutes 2024, section 256B.064, subdivision 1b, is amended to read:

67.19 Subd. 1b. **Sanctions available.** (a) The commissioner may impose the following sanctions
67.20 for the conduct described in subdivision 1a: ~~suspension or withholding of payments to an~~
67.21 ~~individual or entity and suspending or terminating participation in the program, or imposition~~
67.22 ~~of a fine under subdivision 2, paragraph (g).~~

67.23 (1) suspending payments to an individual or entity;

67.24 (2) temporarily withholding payments to an individual or entity;

67.25 (3) suspending participation in the program;

67.26 (4) terminating participation in the program; or

67.27 (5) imposing a fine under subdivision 2a.

67.28 (b) When imposing sanctions under this section, the commissioner ~~shall~~ must consider
67.29 the nature, chronicity, or severity of the conduct and the effect of the conduct on the health
67.30 and safety of persons served by the individual or entity.

(c) The commissioner ~~shall~~ must suspend an individual's or entity's participation in the program for a minimum of five years if the individual or entity is convicted of a crime, received a stay of adjudication, or entered a court-ordered diversion program for an offense related to a provision of a health service under medical assistance, including a federally approved waiver, or health care fraud.

(d) Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

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

Sec. 31. Minnesota Statutes 2024, section 256B.064, subdivision 1c, is amended to read:

Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner may obtain monetary recovery from an individual or entity that has been improperly paid by the department either as a result of conduct described in subdivision 1a or as a result of an error by the individual or entity submitting the claim or by the department, regardless of whether the error was intentional. Patterns need not be proven as a precondition to monetary recovery of erroneous or false claims, duplicate claims, claims for services not medically necessary, or claims based on false statements.

(b) The commissioner may obtain monetary recovery using methods including but not limited to the following: assessing and recovering money improperly paid and debiting from future payments any money improperly paid. The commissioner ~~shall~~ must charge interest on money to be recovered if the recovery is to be made by installment payments or debits, except when the monetary recovery is of an overpayment that resulted from a department error. The interest charged ~~shall~~ must be the rate established by the commissioner of revenue under section 270C.40.

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

Sec. 32. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

Subd. 1d. **Investigative costs.** (a) The commissioner may seek recovery of investigative costs from any individual or entity that willfully submits a claim for reimbursement for services that the individual or entity knows, or reasonably should have known, is a false representation and that results in the payment of public funds for which the individual or entity is ineligible.

(b) Billing errors that result in unintentional overcharges ~~shall~~ are not be grounds for investigative cost recoupment.

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

69.2 Sec. 33. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

69.3 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The
69.4 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions
69.5 to be imposed upon an individual or entity under this section. Except as provided in
69.6 ~~paragraphs (b) and (d), neither~~ subdivision 2c, the commissioner must not obtain a monetary
69.7 recovery ~~nor~~ or impose a sanction ~~will be imposed by the commissioner~~ without prior notice
69.8 and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed
69.9 action, provided that the commissioner may suspend or reduce payment to an individual or
69.10 entity, except a nursing home or convalescent care facility, after notice and prior to the
69.11 hearing if in the commissioner's opinion that action is necessary to protect the public welfare
69.12 and the interests of the program.

69.13 ~~(b) Except when the commissioner finds good cause not to suspend payments under~~
69.14 ~~Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner shall~~
69.15 ~~withhold or reduce payments to an individual or entity without providing advance notice~~
69.16 ~~of such withholding or reduction if either of the following occurs:~~

69.17 ~~(1) the individual or entity is convicted of a crime involving the conduct described in~~
69.18 ~~subdivision 1a; or~~

69.19 ~~(2) the commissioner determines there is a credible allegation of fraud for which an~~
69.20 ~~investigation is pending under the program. Allegations are considered credible when they~~
69.21 ~~have an indicium of reliability and the state agency has reviewed all allegations, facts, and~~
69.22 ~~evidence carefully and acts judiciously on a case-by-case basis. A credible allegation of~~
69.23 ~~fraud is an allegation which has been verified by the state, from any source, including but~~
69.24 ~~not limited to:~~

69.25 ~~(i) fraud hotline complaints;~~

69.26 ~~(ii) claims data mining; and~~

69.27 ~~(iii) patterns identified through provider audits, civil false claims cases, and law~~
69.28 ~~enforcement investigations.~~

69.29 ~~(c) The commissioner must send notice of the withholding or reduction of payments~~
69.30 ~~under paragraph (b) within five days of taking such action unless requested in writing by a~~
69.31 ~~law enforcement agency to temporarily withhold the notice. The notice must:~~

69.32 ~~(1) state that payments are being withheld according to paragraph (b);~~

~~(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;~~

~~(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;~~

~~(4) identify the types of claims to which the withholding applies; and~~

~~(5) inform the individual or entity of the right to submit written evidence for consideration by the commissioner.~~

~~(d) The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the individual or entity, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon conviction for a crime related to the provision, management, or administration of a health service under medical assistance, a payment held pursuant to this section by the commissioner or a managed care organization that contracts with the commissioner under section 256B.035 is forfeited to the commissioner or managed care organization, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered.~~

~~(e) The commissioner shall suspend or terminate an individual's or entity's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the individual's or entity's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:~~

~~(1) state that suspension or termination is the result of the individual's or entity's exclusion from Medicare;~~

~~(2) identify the effective date of the suspension or termination; and~~

~~(3) inform the individual or entity of the need to be reinstated to Medicare before reapplying for participation in the program.~~

~~(f)~~ (b) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, an individual or entity may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the individual or entity. The appeal request must specify:

71.1 (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount
 71.2 involved for each disputed item;

71.3 (2) the computation that the individual or entity believes is correct;

71.4 (3) the authority in statute or rule upon which the individual or entity relies for each
 71.5 disputed item;

71.6 (4) the name and address of the person or entity with whom contacts may be made
 71.7 regarding the appeal; and

71.8 (5) other information required by the commissioner.

71.9 ~~(g) The commissioner may order an individual or entity to forfeit a fine for failure to~~
 71.10 ~~fully document services according to standards in this chapter and Minnesota Rules, chapter~~
 71.11 ~~9505. The commissioner may assess fines if specific required components of documentation~~
 71.12 ~~are missing. The fine for incomplete documentation shall equal 20 percent of the amount~~
 71.13 ~~paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000,~~
 71.14 ~~whichever is less. If the commissioner determines that an individual or entity repeatedly~~
 71.15 ~~violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to~~
 71.16 ~~the provision of services to program recipients and the submission of claims for payment,~~
 71.17 ~~the commissioner may order an individual or entity to forfeit a fine based on the nature,~~
 71.18 ~~severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the~~
 71.19 ~~value of the claims, whichever is greater.~~

71.20 ~~(h) The individual or entity shall pay the fine assessed on or before the payment date~~
 71.21 ~~specified. If the individual or entity fails to pay the fine, the commissioner may withhold~~
 71.22 ~~or reduce payments and recover the amount of the fine. A timely appeal shall stay payment~~
 71.23 ~~of the fine until the commissioner issues a final order.~~

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

71.25 Sec. 34. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
 71.26 to read:

71.27 **Subd. 2a. Imposition of fines.** (a) The commissioner may order an individual or entity
 71.28 to forfeit a fine for failure to fully document services according to standards in this chapter
 71.29 and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required
 71.30 components of documentation are missing. The fine for incomplete documentation equals
 71.31 20 percent of the amount paid on the claims for reimbursement submitted by the individual
 71.32 or entity, or up to \$5,000, whichever is less.

(b) If the commissioner determines that an individual or entity repeatedly violated this chapter, chapter 245G or 254B, or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order an individual or entity to forfeit a fine based on the nature, severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the value of the claims, whichever is greater.

(c) The individual or entity must pay the fine assessed on or before the payment date specified by the commissioner. If the individual or entity fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine.

(d) A timely appeal stays payment of the fine until the commissioner issues a final order.

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

Sec. 35. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision to read:

Subd. 2b. **Mandatory suspension or termination after exclusion from participation in Medicare.** (a) The commissioner must suspend or terminate an individual's or entity's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the individual's or entity's exclusion from participation in Medicare.

(b) Within five days of taking an action under paragraph (a), the commissioner must send notice of the suspension or termination to the individual or entity. The notice must:

(1) state that the suspension or termination is the result of the individual's or entity's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the individual or entity of the need to be reinstated to Medicare before reapplying for participation in the program.

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

Sec. 36. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision to read:

Subd. 2c. **Imposition of withholding or reduction of payments without prior notice.** (a) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner must

73.1 temporarily withhold or reduce payments to an individual or entity without providing advance
73.2 notice of the withholding or reduction if either of the following occurs:

73.3 (1) the individual or entity is convicted of a crime involving the conduct described in
73.4 subdivision 1a; or

73.5 (2) the commissioner determines there is a credible allegation of fraud for which an
73.6 investigation is pending under the program. Allegations are considered credible when the
73.7 allegations have indicia of reliability and the commissioner has reviewed all allegations,
73.8 facts, and evidence carefully and acts judiciously on a case-by-case basis.

73.9 (b) A credible allegation of fraud is an allegation that has been verified by the state from
73.10 any source, including but not limited to:

73.11 (1) fraud hotline complaints;

73.12 (2) claims data mining;

73.13 (3) patterns identified through provider audits, civil false claims cases, and law
73.14 enforcement investigations; and

73.15 (4) court filings and other legal documents, including but not limited to police reports,
73.16 complaints, indictments, informations, affidavits, declarations, and search warrants.

73.17 (c) The commissioner must send notice of the withholding or reduction of payments
73.18 under paragraph (a) within five days of withholding or reducing payments unless requested
73.19 in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

73.20 (1) state that payments are being withheld or reduced according to paragraph (a);

73.21 (2) set forth the allegations as to the nature of the withholding or reduction in a manner
73.22 reasonably calculated to provide notice, which must include but is not limited to date ranges
73.23 of suspected claims, locations of suspected service delivery, and general nature of individual
73.24 or entity conduct, but need not disclose specific information that the commissioner determines
73.25 is likely to jeopardize an ongoing investigation;

73.26 (3) except in the case of a conviction for conduct described in subdivision 1a, state that
73.27 the withholding or reduction is for a temporary period and cite the circumstances under
73.28 which withholding or reduction will be terminated;

73.29 (4) identify the types of claims to which the withholding or reduction applies; and

73.30 (5) inform the individual or entity of the right to submit written evidence for consideration
73.31 by the commissioner.

(d) The commissioner must immediately cease to withhold or reduce payments under this subdivision and must release the withheld or reduced payments no later than ten days following the earlier of the commissioner's determination that there is insufficient evidence of fraud by the individual or entity, or legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions.

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

Sec. 37. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision to read:

Subd. 2d. Administrative review of temporary payment withhold or reduction. (a) Upon receipt of a notice under subdivision 2c, paragraph (c), that a payment withhold or reduction is imposed, an individual or entity may request a review under paragraph (c) by filing with the commissioner a written request for an administrative review. The review request must be received by the commissioner no later than 30 days after the date the notification of the payment withhold or reduction was mailed to the individual or entity. The review request must specify the reason the payment withholding or reduction decision is in error and clearly request a review. The commissioner must refer the review request to the Court of Administrative Hearings within ten business days of receiving the review request.

(b) The costs for the review under paragraph (c) must be borne equally by both parties.

(c) The burden of proof upon review of a temporary withhold or reduction is limited to whether the commissioner can establish that there is a credible allegation of fraud as provided in subdivision 2c, paragraph (a), clause (2). The administrative law judge's recommendation to the commissioner must not make findings on the veracity of the underlying allegations of fraud, as the underlying investigation remains ongoing and underlying facts may be litigated in future administrative, civil, or criminal proceedings after the commissioner issues a final decision.

(d) To protect the integrity of the ongoing investigation, the commissioner must submit evidence to support the action to the administrative law judge under seal. The individual or entity may submit evidence to the administrative law judge that supports the position of the individual or entity that the payment withholding or reduction decision is in error. The administrative law judge must review the evidence in camera. The commissioner must not be subject to discovery by the individual or entity during the proceedings.

(e) The commissioner must provide notice to the individual or entity within ten business days of the administrative law judge's completed recommendation. The notice must state that the review process under this subdivision is complete and must include whether the administrative law judge found that the commissioner established there was a credible allegation of fraud.

(f) The administrative law judge's findings of facts, conclusions of law, and recommendation as to whether there is a credible allegation of fraud must not be used or considered for any other purpose, including impeachment, in any civil, criminal, administrative, or contractual proceeding. The administrative law judge's findings of facts, conclusions of law, and recommendation must not be held conclusive or binding or used as evidence in any separate or subsequent action in any other forum, be it contractual, administrative, or judicial, regardless of whether the action involves the same or related parties or involves the same facts.

Sec. 38. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision to read:

Subd. 2e. **Withholding or reduction of payments; review.** If a payment withhold or reduction under subdivision 2c remains in effect after 90 days, the commissioner must submit evidence to an administrative law judge under seal for the administrative law judge to determine whether the commissioner or a law enforcement agency is actively pursuing an investigation under this section. The administrative law judge must review the evidence in camera and provide a recommendation to the commissioner regarding continuing the withholding or reduction. The recommendation of the administrative law judge is advisory and the commissioner's decision to continue a withholding is final and not subject to appeal or reduction. The review under this subdivision must occur every 90 days for each payment withhold or reduction that is in effect. The commissioner must provide a notice to the individual or entity subject to the payment withhold or reduction within ten business days of the completion of each review under this subdivision. The notice must include the administrative law judge's recommendation.

Sec. 39. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision to read:

Subd. 2f. **Judicial review.** The administrative law judge's findings of facts, conclusions of law, and recommendations under subdivisions 2d and 2e are not subject to judicial review.

76.1 Sec. 40. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
76.2 to read:

76.3 Subd. 2g. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction
76.4 of a crime related to the provision, management, or administration of a health service under
76.5 medical assistance, a payment withheld pursuant to this section by the commissioner or a
76.6 managed care organization that contracts with the commissioner under section 256B.035
76.7 is forfeited to the commissioner or managed care organization, regardless of the amount
76.8 charged in the criminal complaint or the amount of criminal restitution ordered.

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

76.10 Sec. 41. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

76.11 Subd. 3. **Mandates on prohibited payments.** (a) The commissioner ~~shall~~ must maintain
76.12 and publish a list of each excluded individual and entity that was convicted of a crime related
76.13 to the provision, management, or administration of a medical assistance health service, or
76.14 suspended or terminated under ~~subdivision 2~~ this section. Medical assistance payments
76.15 cannot be made by an individual or entity for items or services furnished either directly or
76.16 indirectly by an excluded individual or entity, or at the direction of excluded individuals or
76.17 entities.

76.18 (b) The entity must check the exclusion list on a monthly basis and document the date
76.19 and time the exclusion list was checked and the name and title of the person who checked
76.20 the exclusion list. The entity must immediately terminate payments to an individual or entity
76.21 on the exclusion list.

76.22 (c) An entity's requirement to check the exclusion list and to terminate payments to
76.23 individuals or entities on the exclusion list applies to each individual or entity on the
76.24 exclusion list, even if the named individual or entity is not responsible for direct patient
76.25 care or direct submission of a claim to medical assistance.

76.26 (d) An entity that pays medical assistance program funds to an individual or entity on
76.27 the exclusion list must refund any payment related to either items or services rendered by
76.28 an individual or entity on the exclusion list from the date the individual or entity is first paid
76.29 or the date the individual or entity is placed on the exclusion list, whichever is later, and an
76.30 entity may be subject to:

76.31 (1) sanctions under ~~subdivision 2~~ this section;

(2) a civil monetary penalty of up to \$25,000 for each determination by the department that the vendor employed or contracted with an individual or entity on the exclusion list; and

(3) other fines or penalties allowed by law.

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

Sec. 42. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

Subd. 4. **Notice.** (a) The department ~~shall~~ must serve the notice required under ~~subdivision 2~~ this section using a signature-verified confirmed delivery method to the address submitted to the department by the individual or entity. Service is complete upon mailing.

(b) The department ~~shall~~ must give notice in writing to a recipient placed in the Minnesota restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200. The department ~~shall~~ must send the notice by first class mail to the recipient's current address on file with the department. A recipient placed in the Minnesota restricted recipient program may contest the placement by submitting a written request for a hearing to the department within 90 days of the notice being mailed.

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

Sec. 43. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report is immune from any civil or criminal liability that might otherwise arise from reporting or participating in the investigation. Nothing in this subdivision affects an individual's or entity's responsibility for an overpayment established under this subdivision.

(b) A person employed by a lead investigative agency who is conducting or supervising an investigation or enforcing the law according to the applicable law or rule is immune from any civil or criminal liability that might otherwise arise from the person's actions, if the person is acting in good faith and exercising due care.

(c) For purposes of this subdivision, "person" includes a natural person or any form of a business or legal entity.

(d) After an investigation is complete, the reporter's name must be kept confidential. The subject of the report may compel disclosure of the reporter's name only with the consent of the reporter or upon a written finding by a district court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure

78.1 responsibilities or obligations under the Rules of Criminal Procedure, except that when the
78.2 identity of the reporter is relevant to a criminal prosecution the district court ~~shall~~ must
78.3 conduct an in-camera review before determining whether to order disclosure of the reporter's
78.4 identity.

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

78.6 Sec. 44. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
78.7 to read:

78.8 Subd. 6. **Application.** This section supersedes any inconsistent or contrary provision of
78.9 law.

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

78.11 Sec. 45. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
78.12 to read:

78.13 Subd. 8. **Coordination with law enforcement.** When a temporary withholding or
78.14 reduction of payments under subdivision 2c involves potential criminal conduct, the
78.15 commissioner must coordinate with appropriate law enforcement authorities, including the
78.16 Minnesota attorney general's Medicaid Fraud Control Unit, and may consult with state or
78.17 federal investigative agencies as necessary.

78.18 Sec. 46. **[256B.0647] REMITTANCE ADVICE MONETARY RECOVERY.**

78.19 (a) The commissioner may use the remittance advice process under Code of Federal
78.20 Regulations, title 45, part 162.1601, as the notice to a vendor or provider when seeking
78.21 monetary recovery using a department-administered information technology system for
78.22 programmatically processed claims. The remittance advice must be delivered electronically
78.23 and constitutes the sole notice to the provider. The commissioner must withhold the payments
78.24 at issue when using the remittance advice as the notice.

78.25 (b) Providers may seek reconsideration of a remittance under this section by mailing a
78.26 request to the commissioner. The reconsideration request must be received no later than 30
78.27 calendar days from the posting of the remittance advice. A request for reconsideration does
78.28 not stay the withholding of payments. The commissioner's disposition of a request for
78.29 reconsideration is final and not subject to appeal under chapter 14. The request for
78.30 reconsideration must include:

79.1 (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount
79.2 involved for each disputed item;

79.3 (2) the calculation that the individual or entity believes is correct;

79.4 (3) the authority in statute or rule upon which the individual or entity relies for each
79.5 disputed item;

79.6 (4) the name and address of the person or entity with whom contacts may be made
79.7 regarding the appeal; and

79.8 (5) other information required by the commissioner.

79.9 (c) The commissioner may not use the remittance advice process as notice required
79.10 under section 256B.064.

79.11 Sec. 47. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, as
79.12 amended by Laws 2026, chapter 95, article 4, section 15, is amended to read:

79.13 Subd. 9. **Provider qualifications and duties.** A provider is eligible for reimbursement
79.14 under this section only if the provider:

79.15 (1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk
79.16 assessment under subdivision 10;

79.17 (2) is enrolled as a medical assistance Minnesota health care program provider and meets
79.18 all applicable provider standards and requirements;

79.19 (3) demonstrates compliance with federal and state laws and policies for recuperative
79.20 care services as determined by the commissioner;

79.21 (4) complies with background study requirements under chapter 245C and maintains
79.22 documentation of background study requests and results;

79.23 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
79.24 determined by the commissioner, proof of surety bond coverage for each business location
79.25 providing services. Upon new enrollment, or if the provider's medical assistance revenue
79.26 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
79.27 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
79.28 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
79.29 must be in a form approved by the commissioner, must be renewed annually, and must
79.30 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain
79.31 monetary recovery or sanctions from a surety bond must occur within six years from the
79.32 date the debt is affirmed by a final agency decision. An agency decision is final when the

80.1 right to appeal the debt has been exhausted or the time to appeal has expired under section
80.2 256B.064;

80.3 (6) ensures all controlling individuals and employees of the agency complete annual
80.4 vulnerable adult training;

80.5 (7) completes compliance training as required under section 256B.0446, subdivision 11
80.6 2; and

80.7 (8) complies with the habitability inspection requirements in subdivision 13.

80.8 Sec. 48. Minnesota Statutes 2024, section 256B.076, subdivision 1, is amended to read:

80.9 Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on
80.10 medical assistance receive cost-effective and coordinated care, including efforts to address
80.11 the profound effects of housing instability, food insecurity, and other social determinants
80.12 of health. Therefore, subject to federal approval, medical assistance covers targeted case
80.13 management services as described in this section and sections 245.4711; 245.4881;
80.14 256B.0625, subdivisions 20 to 20b; 256B.0924; 256B.094; and 256F.10.

80.15 (b) The commissioner, in collaboration with Tribes, counties, providers, and individuals
80.16 served, must propose further modifications to targeted case management services to ensure
80.17 a program that complies with all federal requirements, delivers services in a cost-effective
80.18 and efficient manner, creates uniform expectations for targeted case management services,
80.19 addresses health disparities, and promotes person- and family-centered services.

80.20 (c) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
80.21 that does not meet the requirements of this section or section 245.4711; 245.4881; 256B.0625,
80.22 subdivisions 20 and 20b; 256B.0924; 256B.094; or 256F.10. The county of financial
80.23 responsibility, as determined under chapter 256G or, if applicable, the Tribal agency, is
80.24 responsible for any federal disallowances. The county or Tribal agency may share the
80.25 financial responsibility with the county's or Tribal agency's contracted vendors.

80.26 Sec. 49. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
80.27 to read:

80.28 Subd. 5. **County-provided fee-for-service rate setting and reconciliation.** (a) Effective
80.29 January 1 of the implementation year determined in the joint governance agreement under
80.30 subdivision 6, or upon federal approval, whichever is later, the commissioner must pay
80.31 targeted case management services for which counties provide the nonfederal share of
80.32 money and county staff provide the services on a fee-for-service basis according to the

cost-based payment methodology in this subdivision and consistent with the federal regulations related to certified public expenditures. To receive federal reimbursement for these services, a county providing eligible targeted case management services must complete a federally approved cost report in accordance with section 256.01, subdivision 2, paragraph (o).

(b) The commissioner must reimburse submitted claims based on an interim rate and must determine a final rate on a calendar-year basis following completion of a cost report reconciliation. The commissioner must notify counties of the final rate and post final rates publicly.

(c) To appeal a final rate determined by the commissioner under paragraph (b), a county must submit a written appeal request to the commissioner within 60 days after the date the commissioner issued the final rate determination. The appeal request must specify the disputed items and the name and address of the person to contact regarding the appeal.

(d) The payment methodology under this section must only be used to reimburse allowable medical assistance costs. The county of financial responsibility, as determined under chapter 256G, is responsible for any federal disallowances.

(e) Upon implementation, the commissioner must base interim rates on data from the testing period. The commissioner must base subsequent interim rates for a calendar year on the most recently completed reconciliation. The commissioner must notify counties of the interim rate by June 30 each year and post interim rates publicly. If the commissioner is unable to notify the counties by June 30, the commissioner must notify each county in writing no later than June 30 that the new interim rate is delayed and must provide an estimate of when the new interim rate will be available.

(f) Payments to counties for targeted case management expenditures under this section must be made only from federal earnings from services provided under this section.

(g) Counties must submit all claims for targeted case management services described in this section using a 15-minute unit.

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

Sec. 50. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

Subd. 6. Testing and implementation. The commissioners of human services and children, youth, and families; the Association of Minnesota Counties (AMC); and the

82.1 Minnesota Association of County Social Service Administrators (MACSSA) must collaborate
82.2 to establish a joint governance agreement. The joint governance agreement must:

82.3 (1) establish system functionality requirements to (i) meet the business needs of local
82.4 agencies providing targeted case management services and (ii) comply with applicable state
82.5 and federal regulations for the Social Services Information System (SSIS), SSIS's
82.6 replacement, and adjacent systems and the targeted case management cost report under
82.7 subdivision 5;

82.8 (2) establish a schedule for transition planning, including but not limited to fiscal impact
82.9 assessment and training; and

82.10 (3) specify that the rate method established in subdivision 5 must not be implemented
82.11 without both the completion of a required testing period of 12 calendar months and the
82.12 express approval by the commissioners of human services and children, youth, and families;
82.13 AMC; and MACSSA.

82.14 Sec. 51. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
82.15 to read:

82.16 Subd. 7. **Managed care plan units and rates for mental health targeted case**
82.17 **management.** The commissioner must ensure that the prepaid health plans providing covered
82.18 health services for eligible persons pursuant to this chapter and section 256L.03, subdivisions
82.19 1a and 1b, reimburse counties at a rate that is at least equal to the fee-for-service rate
82.20 described in subdivision 5 for targeted case management services provided to Minnesota
82.21 health care program (MHCP) health plan enrollees covered by medical assistance. If, for
82.22 any contract year, federal approval is not received for this subdivision, the commissioner
82.23 must adjust the capitation rates paid to managed care plans and county-based purchasing
82.24 plans for that contract year to reflect the removal of this subdivision. Contracts between
82.25 managed care plans and county-based purchasing plans and providers to whom this
82.26 subdivision applies must allow recovery of payments from those providers if capitation
82.27 rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed
82.28 the amount equal to any increase in rates that results from this subdivision. This subdivision
82.29 expires if federal approval is not received for this subdivision at any time. This subdivision
82.30 does not obligate MHCP health plans to contract with counties for the provision of targeted
82.31 case management services.

83.1 Sec. 52. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
83.2 to read:

83.3 Subd. 8. Targeted case management gap funding. (a) For purposes of this subdivision,
83.4 "unacceptable loss" means when a county's finalized amount of targeted case management
83.5 federal reimbursement following the commissioner's reconciliation for a calendar year for
83.6 targeted case management under subdivision 5 is less than 90 percent of the average federal
83.7 reimbursement received by that county during the base calendar years determined in
83.8 paragraph (c).

83.9 (b) The commissioner must pay targeted case management gap funding in the amount
83.10 and time frame specified in paragraph (c) to an individual county for calendar years in which
83.11 the county experiences an unacceptable loss.

83.12 (c) The base calendar years are the three calendar years immediately before the testing
83.13 period of 12 calendar months determined under subdivision 6. In consultation with the
83.14 county that experienced the unacceptable loss, the commissioner must make appropriate
83.15 adjustments to base year amounts as needed to prevent the base amounts from being unduly
83.16 influenced by onetime events, anomalies, or small changes that appear large compared to
83.17 a narrow historical base. The commissioner must not make adjustments to the eight county
83.18 human services agencies that received the greatest amount of targeted case management
83.19 federal reimbursement during the base calendar years. For agencies other than the eight
83.20 county human services agencies that received the greatest amount, the total of all adjustments
83.21 for a given calendar year must not exceed two percent of statewide federal targeted case
83.22 management federal reimbursement that calendar year.

83.23 (d) The commissioner must pay targeted case management gap funding to the applicable
83.24 county in an amount equaling the difference between the finalized amount of targeted case
83.25 management federal reimbursement after reconciliation for that calendar year and 90 percent
83.26 of the average federal reimbursement received by that county during the base calendar years,
83.27 including any adjustments under paragraph (c). The commissioner must pay the county
83.28 within 90 days of completing the reconciliation under subdivision 5.

83.29 (e) Targeted case management gap funding is a forecasted program under section 16A.11.

84.1 Sec. 53. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, as
84.2 amended by Laws 2026, chapter 88, article 1, section 126, and Laws 2026, chapter 95,
84.3 article 4, section 21, is amended to read:

84.4 Subd. 6. **Payment for targeted case management.** (a) ~~Medical assistance and~~
84.5 ~~MinnesotaCare payment for targeted case management shall be made on a monthly basis.~~
84.6 ~~In order to receive payment for an eligible adult, The provider must document at least one~~
84.7 ~~contact per month and not more than two consecutive months without a face-to-face meet~~
84.8 ~~the contact either in person or requirements under section 256B.094, subdivision 6. Contact~~
84.9 ~~by interactive video that meets must meet the requirements in section 256B.0625, subdivision~~
84.10 ~~20b, with the adult or the adult's legal representative, family, primary caregiver, or other~~
84.11 ~~relevant persons person identified as necessary to the development or implementation of~~
84.12 ~~the goals of the personal service plan.~~

84.13 (b) Except as provided under paragraph (m), payment for targeted case management
84.14 provided by county staff under this subdivision ~~shall~~ must be based on the ~~monthly rate~~
84.15 ~~methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one~~
84.16 ~~combined average rate together with adult mental health case management under section~~
84.17 ~~256B.0625, subdivision 20~~ established in section 256B.076, subdivisions 5 and 7. Billing
84.18 and payment must identify the recipient's primary population group to allow tracking of
84.19 revenues.

84.20 (c) Payment for targeted case management provided by county-contracted vendors shall
84.21 be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2.
84.22 Payment for case management provided by vendors who contract with a Tribe must be made
84.23 in accordance with Indian Health Service facility requirements. If a Tribe chooses to contract
84.24 with a vendor receiving payment not through an Indian Health Service facility, the rate must
84.25 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
84.26 by the vendor for the same service to other payers. If the service is provided by a team of
84.27 contracted vendors, the team shall determine how to distribute the rate among its members.
84.28 No reimbursement received by contracted vendors shall be returned to the county or Tribe,
84.29 except to reimburse the county or Tribe for advance funding provided by the county or
84.30 Tribe to the vendor.

84.31 (d) If the service is provided by a team that includes any combination of contracted
84.32 vendors, county staff, and Tribal staff, the costs for county staff participation on the team
84.33 shall be included in the rate for county-provided services. In this case, the contracted vendor
84.34 and the county and Tribal case managers may each receive separate payment for services
84.35 provided by each entity in the same month. In order to prevent duplication of services, each

85.1 entity must document the need for team targeted case management and a description of the
85.2 different roles of staff.

85.3 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
85.4 targeted case management shall be provided by the recipient's county of responsibility, as
85.5 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
85.6 used to match other federal funds. If the service is provided by a Tribal agency, the recipient's
85.7 Tribe must provide the nonfederal share of costs, if any.

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

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

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

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

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

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

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

85.31 (k) Payment for targeted case management services under this subdivision shall not
85.32 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 or Tribes.

(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.

Sec. 54. Minnesota Statutes 2024, section 256B.094, subdivision 2, is amended to read:

Subd. 2. **Eligible services.** Services eligible for medical assistance reimbursement include:

(1) assessment of the recipient's need for case management services to gain access to available medical, social, educational, economic support, and other related services;

(2) development, completion, and regular review of a written individual service plan based on the assessment of need for case management services to ensure access to available medical, social, educational, economic support, and other related services;

(3) routine contact or other communication with the client, the client's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan, regarding the status of the client, the individual service plan, or the goals for the client, exclusive of transportation of the child;

(4) coordinating referrals for, and the provision of, case management services for the client with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery to ensure quality of services;

(6) monitoring and evaluating services on a regular basis to ensure appropriateness and continued need based on the child's and family's or caregiver's current circumstances;

(7) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(8) traveling to conduct a visit with the client or other relevant person necessary to the development or implementation of the goals of the individual service plan; and

(9) coordinating with the medical assistance facility discharge planner in the 30-day period before the client's discharge into the community. This case management service

87.1 provided to patients or residents in a medical assistance facility is limited to a maximum of
87.2 two 30-day periods per calendar year.

87.3 Sec. 55. Minnesota Statutes 2024, section 256B.094, subdivision 3, is amended to read:

87.4 Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where
87.5 a ~~prepaid medical assistance provider~~ managed care organization (MCO) or county-based
87.6 purchasing (CBP) plan has contracted under section 256B.69 to provide medical and mental
87.7 health services, the case management provider shall coordinate with the ~~prepaid provider~~
87.8 MCO or CBP plan to ensure that all necessary medical and mental health services required
87.9 under the contract are provided to recipients of case management services.

87.10 ~~(b) When the case management provider determines that a prepaid provider is not~~
87.11 ~~providing mental health services as required under the contract, the case management~~
87.12 ~~provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section~~
87.13 ~~256.045, and may make other arrangements for provision of the covered services.~~

87.14 ~~(c) The case management provider may bill the provider of prepaid health care services~~
87.15 ~~for any mental health services provided to a recipient of case management services which~~
87.16 ~~the county or tribal social services arranges for or provides and which are included in the~~
87.17 ~~prepaid provider's contract, and which were determined to be medically necessary as a result~~
87.18 ~~of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental~~
87.19 ~~health provider, at the prepaid provider's standard rate for that service, for any services~~
87.20 ~~delivered under this subdivision.~~

87.21 (b) Child welfare targeted case management is carved out of Minnesota health care
87.22 programs managed care contracts. The case management provider must assist the recipient
87.23 to ensure access to all medically necessary services listed in section 256B.0625, whether
87.24 delivered on a fee-for-service basis or by a MCO or CBP plan.

87.25 ~~(d)~~ (c) If the county or Tribal social services has not obtained prior authorization for this
87.26 service, or an appeal results in a determination that the services were not medically necessary,
87.27 the county or Tribal social services may not seek reimbursement from the prepaid provider.

87.28 Sec. 56. Minnesota Statutes 2024, section 256B.094, subdivision 6, is amended to read:

87.29 Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical
87.30 assistance reimbursement for services under this section ~~shall~~ must be made ~~on a monthly~~
87.31 ~~basis~~ in accordance with section 256B.076. Payment is based on face-to-face contacts either
87.32 in person or by interactive video, or telephone contacts between the case manager and the

client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the following requirements:

(1) there must be a face-to-face contact either in person or by interactive video that meets the requirements of section 256B.0625, subdivision 20b, at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by Tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face, in-person contact.

~~(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482 and 256.01, subdivision 2, paragraph (e).~~

~~(e)~~ (b) Payments for Tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a Tribe or Tribal organization.

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

~~(e)~~ (d) If the service is provided by a team that includes contracted vendors and county or Tribal social services staff, the costs for county or Tribal social services staff participation in the team shall be included in the rate for county or Tribal social services provided services. In this case, the contracted vendor and the county or Tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent

duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

~~Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.~~

Sec. 57. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, as amended by Laws 2026, chapter 95, article 4, section 24, 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,~~ sections 256B.044 to 256B.0448 and meet all applicable provider standards and requirements;

(2) designate an individual as the agency's compliance officer who must perform the duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

(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;

(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;

(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;

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

(8) initiate a background study as required under subdivision 16a;

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

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

(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;

(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;

(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;

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

(15) provide clinical supervision for a minimum of one hour for every 16 hours of direct treatment per person, unless otherwise authorized in the person's individual treatment plan; and

(16) provide the required EIDBI intervention observation and direction by a QSP at least once per month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention observation and direction under this clause may be conducted via telehealth provided that no more than two consecutive monthly required EIDBI intervention observation and direction sessions under this clause are conducted via telehealth.

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

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

91.5 (2) provide disclosures of the use of billing agencies and other consultants who do not
91.6 provide EIDBI services; and

91.7 (3) provide copies of any contracts with consultants or independent contractors who do
91.8 not provide EIDBI services, including hours contracted and responsibilities.

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

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

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

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

91.19 Sec. 58. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

91.20 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the
91.21 Early Intensive Developmental and Behavioral Intervention Advisory Council and
91.22 stakeholders, including agencies, professionals, parents of people with ASD or a related
91.23 condition, and advocacy organizations, the commissioner shall determine if a shortage of
91.24 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"
91.25 means a lack of availability of providers who meet the EIDBI provider qualification
91.26 requirements under subdivision 15 that results in the delay of access to timely services under
91.27 this section, or that significantly impairs the ability of a provider agency to have sufficient
91.28 providers to meet the requirements of this section. The commissioner shall consider
91.29 geographic factors when determining the prevalence of a shortage. The commissioner may
91.30 determine that a shortage exists only in a specific region of the state, multiple regions of
91.31 the state, or statewide. The commissioner shall also consider the availability of various types
91.32 of treatment modalities covered under this section.

(b) The commissioner, in consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, must establish processes and criteria for granting an exception under this paragraph. The commissioner may grant an exception only if the exception would not compromise a person's safety and not diminish the effectiveness of the treatment. The commissioner may establish an expiration date for an exception granted under this paragraph. The commissioner may grant an exception for the following:

(1) EIDBI provider qualifications under this section;

(2) medical assistance provider enrollment requirements under ~~section 256B.04,~~
~~subdivision 21~~ sections 256B.044 to 256B.0448; or

(3) EIDBI provider or agency standards or requirements.

(c) If the commissioner, in consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no longer exists, the commissioner must submit a notice that a shortage no longer exists to the chairs and ranking minority members of the senate and the house of representatives committees with jurisdiction over health and human services. The commissioner must post the notice for public comment for 30 days. The commissioner shall consider public comments before submitting to the legislature a request to end the shortage declaration. The commissioner shall not declare the shortage of EIDBI providers ended without direction from the legislature to declare it ended.

Sec. 59. Minnesota Statutes 2024, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each

performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans:

(1) use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85;

(2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract; ~~and~~

(3) use a six-month timely filing standard and provide an exemption to the timely filing timeliness for the resubmission of claims where there has been a denial, request for more information, or system issue;

(4) have in place a prepayment review process for all claims that includes claims edit processing and policies consistent with the procedures under section 256B.0447; and

94.1 (5) publish metrics related to program integrity actions and outcomes on a publicly
94.2 available website.

94.3 (e) Effective for services rendered on or after January 1, 2013, through December 31,
94.4 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
94.5 this section and county-based purchasing plan payments under section 256B.692 for the
94.6 prepaid medical assistance program. The withheld funds must be returned no sooner than
94.7 July 1 and no later than July 31 of the following year. The commissioner may exclude
94.8 special demonstration projects under subdivision 23.

94.9 (f) Effective for services rendered on or after January 1, 2014, the commissioner shall
94.10 withhold three percent of managed care plan payments under this section and county-based
94.11 purchasing plan payments under section 256B.692 for the prepaid medical assistance
94.12 program. The withheld funds must be returned no sooner than July 1 and no later than July
94.13 31 of the following year. The commissioner may exclude special demonstration projects
94.14 under subdivision 23.

94.15 (g) A managed care plan or a county-based purchasing plan under section 256B.692
94.16 may include as admitted assets under section 62D.044 any amount withheld under this
94.17 section that is reasonably expected to be returned.

94.18 (h) Contracts between the commissioner and a prepaid health plan are exempt from the
94.19 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
94.20 7.

94.21 (i) The return of the withhold under paragraphs (e) and (f) is not subject to the
94.22 requirements of paragraph (c).

94.23 (j) Managed care plans and county-based purchasing plans shall maintain current and
94.24 fully executed agreements for all subcontractors, including bargaining groups, for
94.25 administrative services that are expensed to the state's public health care programs.
94.26 Subcontractor agreements determined to be material, as defined by the commissioner after
94.27 taking into account state contracting and relevant statutory requirements, must be in the
94.28 form of a written instrument or electronic document containing the elements of offer,
94.29 acceptance, consideration, payment terms, scope, duration of the contract, and how the
94.30 subcontractor services relate to state public health care programs. Upon request, the
94.31 commissioner shall have access to all subcontractor documentation under this paragraph.
94.32 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
94.33 to section 13.02.

95.1 (k) The commissioner has the right to recover from a managed care plan the full monetary
95.2 amount of any claims identified as improperly paid during audits or investigations by the
95.3 commissioner or the commissioner's contractors or the Centers for Medicare and Medicaid
95.4 Services.

95.5 Sec. 60. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision
95.6 to read:

95.7 Subd. 10a. **Data sharing for program integrity.** If the commissioner receives a written
95.8 report from a managed care plan that has reason to believe that a provider, vendor, managed
95.9 care employee, subcontractor, or enrollee committed fraud under this chapter or chapter
95.10 256L, the commissioner must provide summary data, as defined in section 13.02, subdivision
95.11 19, from the report to other managed care plans contracted under this section within ten
95.12 days of receiving the report. Nothing in this subdivision allows release of information that
95.13 is nonpublic data pursuant to section 13.02, subdivision 9.

95.14 Sec. 61. Minnesota Statutes 2024, section 256B.69, subdivision 37, is amended to read:

95.15 Subd. 37. **Networks.** (a) The commissioner shall ensure that a managed care
95.16 organization's network providers are enrolled with the commissioner as medical assistance
95.17 providers, and that the providers comply with the provider disclosure, screening, and
95.18 enrollment requirements in Code of Federal Regulations, part 42, section 455. A provider
95.19 that has a network provider contract with the managed care organization is not required to
95.20 provide services to a medical assistance or MinnesotaCare recipient who is receiving services
95.21 through the fee-for-service system.

95.22 (b) A managed care organization may enter into a network provider contract with a
95.23 provider that is not a medical assistance provider for a period of up to 120 days pending the
95.24 outcome of the medical assistance provider enrollment process. A managed care organization
95.25 must terminate the contract upon notification that the provider cannot be enrolled as a
95.26 medical assistance provider or upon expiration of the 120-day period if notification has not
95.27 been received within that period. The managed care organization must notify each affected
95.28 enrollee of the provider contract termination.

95.29 (c) For purposes of this subdivision, "network provider" means any provider, group of
95.30 providers, entity with a network provider agreement with the managed care organization,
95.31 or subcontractor that receives payments from the managed care organization either directly
95.32 or indirectly to provide services under a managed care contract between the commissioner
95.33 and the managed care organization.

96.1 (d) A managed care organization is not required to include a provider in its network
96.2 before approving the provider's credentials in accordance with section 62Q.097.

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

96.4 Sec. 62. Laws 2025, First Special Session chapter 3, article 8, section 43, the effective
96.5 date, is amended to read:

96.6 **EFFECTIVE DATE.** Paragraph (b) is effective ~~July 1, 2026, for medical assistance~~
96.7 ~~fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation
96.8 of the administrator under Minnesota Statutes, section 256B.0625, subdivision 18i. The
96.9 commissioner of human services must notify the revisor of statutes when the administrator
96.10 under Minnesota Statutes, section 256B.0625, subdivision 18i, is implemented. Paragraph
96.11 (c) is effective on the latest of the following: (1) January 1, 2026; (2) federal approval of
96.12 the medical assistance program changes in this section; (3) federal approval of the
96.13 amendments in this act to Minnesota Statutes, section 256B.76, subdivision 6; (4) federal
96.14 approval of the amendments in this act to Minnesota Statutes, section 256B.761; or (5)
96.15 federal approval of all necessary federal waivers to implement the managed care organization
96.16 assessment in Minnesota Statutes, section 295.525. The commissioner of human services
96.17 shall notify the revisor of statutes when federal approval is obtained.

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

96.19 Sec. 63. **MANDATORY COMPLIANCE TRAINING FOR CURRENTLY**
96.20 **ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

96.21 The owners and employees of any medical assistance provider agency subject to the
96.22 requirements of Minnesota Statutes, section 256B.0446, subdivision 2, and enrolled before
96.23 January 1, 2027, must complete initial compliance training by January 1, 2028.

96.24 Sec. 64. **REPEALER.**

96.25 Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 11, is repealed.

96.26 **ARTICLE 4**

96.27 **DEPARTMENT OF HUMAN SERVICES OIG POLICY**

96.28 Section 1. Minnesota Statutes 2024, section 245.095, subdivision 2, is amended to read:

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

97.1 (b) "Associated entity" means a provider or vendor owned or controlled by an excluded
97.2 individual.

97.3 (c) "Associated individual" means an individual or entity that has a relationship with
97.4 the business or its owners or controlling individuals, such that the individual or entity would
97.5 have knowledge of the financial practices of the program in question.

97.6 (d) "Convicted" means a judgment of conviction has been entered by a federal, state, or
97.7 local court, regardless of whether an appeal from the judgment is pending, and includes a
97.8 stay of adjudication, a court-ordered diversion program, or a plea of guilty or nolo contendere.

97.9 (e) "Credible allegation of fraud" means an allegation that has been verified by the
97.10 commissioner from any source, including but not limited to:

97.11 (1) fraud hotline complaints;

97.12 (2) claims data mining;

97.13 (3) patterns identified through provider audits, civil false claims cases, and law
97.14 enforcement investigations;

97.15 (4) court filings and other legal documents, including but not limited to police reports,
97.16 complaints, indictments, informations, affidavits, declarations, and search warrants; and

97.17 (5) information from the inspector general appointed under chapter 15E, including
97.18 information listed on the inspector general's exclusion list under section 15E.25, subdivision
97.19 1, clause (11).

97.20 Allegations are credible when they have an indicium of reliability and the state agency has
97.21 reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case
97.22 basis.

97.23 ~~(d)~~ (f) "Excluded" means removed under other authorities from a program administered
97.24 by a Minnesota state or federal agency, including. Excluded includes but is not limited to:

97.25 (1) a final determination to stop payments;

97.26 (2) a conclusive background study disqualification, except for a disqualification issued
97.27 under section 245C.15, subdivision 4c, that has not been set aside or had a variance granted
97.28 under section 245C.30; and

97.29 (3) a final agency decision regarding a denial of a license application.

97.30 (g) "Fraud" has the meaning given in section 256B.02, subdivision 20.

98.1 ~~(e)~~ (h) "Individual" means a natural person providing products or services as a provider
98.2 or vendor.

98.3 ~~(f)~~ (i) "Provider" means any entity, individual, owner, controlling individual, license
98.4 holder, director, or managerial official of an entity receiving payment from a program
98.5 administered by a Minnesota state or federal agency.

98.6 Sec. 2. Minnesota Statutes 2024, section 245.095, subdivision 5, as amended by Laws
98.7 2026, chapter 92, article 2, section 12, is amended to read:

98.8 Subd. 5. **Withholding of payments.** (a) Except as otherwise provided by state or federal
98.9 law, the commissioner may withhold payments to a provider, vendor, individual, associated
98.10 individual, or associated entity in any program administered by the commissioner if the
98.11 commissioner determines:

98.12 (1) there is a credible allegation of fraud for which an investigation is pending for a
98.13 program administered by a Minnesota state or federal agency;

98.14 (2) the individual, the entity, or an associated individual or entity was convicted of a
98.15 crime, in state or federal court, for an offense that involves fraud or theft against a program
98.16 administered by the commissioner or another state or federal agency;

98.17 (3) the provider is operating after a state or federal agency orders the suspension,
98.18 revocation, or decertification of the provider's license or certification, or if the provider is
98.19 subject to a temporary immediate suspension, regardless of whether the action is under
98.20 appeal; or

98.21 (4) the provider, vendor, individual, associated individual, or associated entity, including
98.22 those receiving funds under any contract or registered program, has a background study
98.23 disqualification under section 245C.15, subdivisions 1 to 4b, that has not been set aside and
98.24 for which no variance has been issued.

98.25 ~~(b) For purposes of this subdivision, "credible allegation of fraud" means an allegation~~
98.26 ~~that has been verified by the commissioner from any source, including but not limited to:~~

98.27 ~~(1) fraud hotline complaints;~~

98.28 ~~(2) claims data mining;~~

98.29 ~~(3) patterns identified through provider audits, civil false claims cases, and law~~
98.30 ~~enforcement investigations;~~

98.31 ~~(4) court filings and other legal documents, including but not limited to police reports,~~
98.32 ~~complaints, indictments, informations, affidavits, declarations, and search warrants; and~~

99.1 ~~(5) information from the inspector general appointed under chapter 15E, including~~
99.2 ~~information listed on the inspector general's exclusion list under section 15E.25, subdivision~~
99.3 ~~1, clause (11).~~

99.4 ~~(e)~~ (b) The commissioner must send notice of the withholding of payments within five
99.5 days of taking such action. The notice must:

99.6 (1) state that payments are being withheld according to this subdivision;

99.7 (2) set forth the general allegations related to the withholding action, except the notice
99.8 need not disclose specific information concerning an ongoing investigation;

99.9 (3) state that the withholding is for a temporary period and cite the circumstances under
99.10 which the withholding will be terminated; and

99.11 (4) inform the provider, vendor, individual, associated individual, or associated entity
99.12 of the right to submit written evidence to contest the withholding action for consideration
99.13 by the commissioner.

99.14 ~~(d)~~ (c) If the commissioner withholds payments under this subdivision, the provider,
99.15 vendor, individual, associated individual, or associated entity has a right to request
99.16 administrative reconsideration. A request for administrative reconsideration must be made
99.17 in writing, state with specificity the reasons the payment withholding decision is in error,
99.18 and include documents to support the request. Within 60 days from receipt of the request,
99.19 the commissioner shall judiciously review allegations, facts, evidence available to the
99.20 commissioner, and information submitted by the provider, vendor, individual, associated
99.21 individual, or associated entity to determine whether the payment withholding should remain
99.22 in place.

99.23 ~~(e)~~ (d) The commissioner shall stop withholding payments if the commissioner determines
99.24 there is insufficient evidence of fraud by the provider, vendor, individual, associated
99.25 individual, or associated entity or when legal proceedings relating to the alleged fraud are
99.26 completed, unless the commissioner has sent notice under subdivision 3 to the provider,
99.27 vendor, individual, associated individual, or associated entity.

99.28 ~~(f)~~ (e) The withholding of payments under this section is a temporary action and is not
99.29 subject to appeal under section 256.045 or chapter 14.

99.30 (f) Section 15.013 does not apply to the commissioner taking action under this section.

Sec. 3. Minnesota Statutes 2024, section 245A.02, subdivision 13, is amended to read:

Subd. 13. **Individual who is related.** "Individual who is related" means a spouse, a parent, a birth or adopted child or stepchild, a stepparent, a stepbrother, a stepsister, a niece, a nephew, an adoptive parent, a grandparent, a sibling, an aunt, an uncle, or a legal guardian. Individual who is related includes an individual who has a relationship named in this subdivision through marriage.

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

Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not misuse substances or have a substance use disorder, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or substance use disorder treatment;

(9) programs licensed by the commissioner of corrections;

- 101.1 (10) recreation programs for children or adults that are operated or approved by a park
101.2 and recreation board whose primary purpose is to provide social and recreational activities;
- 101.3 (11) noncertified boarding care homes unless they provide services for five or more
101.4 persons whose primary diagnosis is mental illness or a developmental disability;
- 101.5 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art
101.6 programs, and nonresidential programs for children provided for a cumulative total of less
101.7 than 30 days in any 12-month period;
- 101.8 (13) residential programs for persons with mental illness, that are located in hospitals;
- 101.9 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter
101.10 4630;
- 101.11 (15) mental health outpatient services for adults with mental illness or children with
101.12 mental illness;
- 101.13 (16) residential programs serving school-age children whose sole purpose is cultural or
101.14 educational exchange, until the commissioner adopts appropriate rules;
- 101.15 (17) community support services programs as defined in section 245.462, subdivision
101.16 6, and family community support services as defined in section 245.4871, subdivision 17;
- 101.17 (18) assisted living facilities licensed by the commissioner of health under chapter 144G;
- 101.18 (19) substance use disorder treatment activities of licensed professionals in private
101.19 practice as defined in section 245G.01, subdivision 17;
- 101.20 (20) consumer-directed community support service funded under the Medicaid waiver
101.21 for persons with developmental disabilities when the individual who provided the service
101.22 is:
- 101.23 (i) the same individual who is the direct payee of these specific waiver funds or paid by
101.24 a fiscal agent, fiscal intermediary, or employer of record; and
- 101.25 (ii) not otherwise under the control of a residential or nonresidential program that is
101.26 required to be licensed under this chapter when providing the service;
- 101.27 (21) a county that is an eligible vendor under section 254B.0501 to provide care
101.28 coordination and comprehensive assessment services;
- 101.29 (22) a recovery community organization that is an eligible vendor under section
101.30 254B.0501 to provide peer recovery support services; or

102.1 (23) programs licensed by the commissioner of children, youth, and families in chapter
102.2 142B.

102.3 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
102.4 building in which a nonresidential program is located if it shares a common wall with the
102.5 building in which the nonresidential program is located or is attached to that building by
102.6 skyway, tunnel, atrium, or common roof.

102.7 (c) Except for the home and community-based services identified in section 245D.03,
102.8 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
102.9 provided and funded according to an approved federal waiver plan where licensure is
102.10 specifically identified as not being a condition for the services and funding.

102.11 (d) Notwithstanding section 245A.02, subdivision 13, programs initially licensed prior
102.12 to July 1, 2026, may continue to operate under and must comply with the definition of
102.13 related individual in Minnesota Statutes 2024, section 245A.02, subdivision 13, until the
102.14 service recipient related to the license holder is no longer receiving services licensed under
102.15 this chapter.

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

102.17 Sec. 5. Minnesota Statutes 2024, section 245A.043, subdivision 2, is amended to read:

102.18 Subd. 2. **Change in ownership.** ~~(a)~~ If the commissioner determines that there is a change
102.19 in ownership, the commissioner shall require submission of a new license application. This
102.20 subdivision does not apply to a licensed program or service located in a home where the
102.21 license holder resides. A change in ownership occurs when:

102.22 (1) ~~except as provided in paragraph (b),~~ the license holder sells or transfers 100 percent
102.23 of the property, stock, or assets;

102.24 (2) the license holder merges with another organization;

102.25 (3) the license holder consolidates with two or more organizations, resulting in the
102.26 creation of a new organization;

102.27 (4) there is a change to the federal tax identification number associated with the license
102.28 holder; or

102.29 (5) ~~except as provided in paragraph (b),~~ all controlling individuals for the original license
102.30 have changed.

102.31 ~~(b) For changes under paragraph (a), clause (1) or (5), no change in ownership has~~
102.32 ~~occurred and a new license application is not required if at least one controlling individual~~

103.1 ~~has been affiliated as a controlling individual for the license for at least the previous 12~~
103.2 ~~months immediately preceding the change.~~

103.3 **EFFECTIVE DATE.** This section is effective October 1, 2026.

103.4 Sec. 6. Minnesota Statutes 2025 Supplement, section 245A.043, subdivision 2a, is amended
103.5 to read:

103.6 Subd. 2a. **Review of change in ownership.** (a) After a change in ownership under
103.7 subdivision 2, ~~paragraph (a)~~, the commissioner may complete a review for all new license
103.8 holders within 12 months after the new license is issued.

103.9 ~~(b) For all license holders subject to the exception in subdivision 2, paragraph (b), the~~
103.10 ~~license holder must notify the commissioner of the date of the change in controlling~~
103.11 ~~individuals pursuant to section 245A.04, subdivision 7a, and the commissioner may complete~~
103.12 ~~a review within 12 months following the change.~~

103.13 **EFFECTIVE DATE.** This section is effective October 1, 2026.

103.14 Sec. 7. Minnesota Statutes 2024, section 245A.07, subdivision 2a, is amended to read:

103.15 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of
103.16 receipt of the license holder's timely appeal, the commissioner shall request assignment of
103.17 an administrative law judge. The request must include a proposed date, time, and place of
103.18 a hearing. A hearing must be conducted by an administrative law judge within 30 calendar
103.19 days of the request for assignment, unless an extension is requested by either party and
103.20 granted by the administrative law judge for good cause. The commissioner shall issue a
103.21 notice of hearing by certified mail or personal service at least ten working days before the
103.22 hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary
103.23 immediate suspension should remain in effect pending the commissioner's final order under
103.24 section 245A.08, regarding a licensing sanction issued under subdivision 3 following the
103.25 immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the
103.26 burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only
103.27 if the commissioner's demonstration commissioner demonstrates that reasonable cause exists
103.28 to believe that the license holder's or controlling individual's actions or failure to comply
103.29 with applicable law or rule poses, or the actions of other individuals or conditions in the
103.30 program poses an imminent risk of harm to the health, safety, or rights of persons served
103.31 by the program. "Reasonable cause" means there exist specific articulable facts or
103.32 circumstances which provide the commissioner with a reasonable suspicion that there is an
103.33 imminent risk of harm to the health, safety, or rights of persons served by the program.

104.1 When the commissioner has determined there is reasonable cause to order the temporary
104.2 immediate suspension of a license based on a violation of safe sleep requirements, as defined
104.3 in section 245A.1435, the commissioner is not required to demonstrate that an infant died
104.4 or was injured as a result of the safe sleep violations. For suspensions under subdivision 2,
104.5 paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision
104.6 ~~shall be limited to~~ is met only if the commissioner's demonstration commissioner
104.7 demonstrates by a preponderance of the evidence that, since the license was revoked, the
104.8 license holder committed additional violations of law or rule which may adversely affect
104.9 the health or safety of persons served by the program.

104.10 (b) The administrative law judge shall issue findings of fact, conclusions, and a
104.11 recommendation within ten working days from the date of hearing. The parties shall have
104.12 ten calendar days to submit exceptions to the administrative law judge's report. The record
104.13 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
104.14 final order shall be issued within ten working days from the close of the record. When an
104.15 appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner
104.16 shall issue a final order affirming the temporary immediate suspension within ten calendar
104.17 days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days
104.18 after an immediate suspension has been issued and the license holder has not submitted a
104.19 timely appeal under subdivision 2, paragraph (b), or within 90 calendar days after a final
104.20 order affirming an immediate suspension, the commissioner shall determine:

104.21 (1) whether a final licensing sanction shall be issued under subdivision 3, paragraph (a),
104.22 clauses (1) to ~~(6)~~ (5). The license holder shall continue to be prohibited from operation of
104.23 the program during this 90-day period; ~~or~~

104.24 (2) whether the outcome of related, ongoing investigations or judicial proceedings are
104.25 necessary to determine if a final licensing sanction under subdivision 3, paragraph (a),
104.26 clauses (1) to ~~(6)~~ (5), will be issued and whether persons served by the program remain at
104.27 an imminent risk of harm during the investigation period or proceedings. If so, the
104.28 commissioner shall issue a suspension order under subdivision 3, paragraph (a), clause ~~(7)~~.
104.29 (6); or

104.30 (3) whether the license holder or controlling individual remains the subject of a pending
104.31 administrative, civil, or criminal investigation or subject to an administrative or civil action
104.32 related to fraud against a program administered by a state or federal agency. If so, the
104.33 commissioner shall issue a suspension order under subdivision 3, paragraph (a), clause (6).

(c) When the final order under paragraph (b) affirms an immediate suspension, or the license holder does not submit a timely appeal of the immediate suspension, and a final licensing sanction is issued under subdivision 3 and the license holder appeals that sanction, the license holder continues to be prohibited from operation of the program pending a final commissioner's order under section 245A.08, subdivision 5, regarding the final licensing sanction.

(d) The license holder shall continue to be prohibited from operation of the program while a suspension order issued under paragraph (b), clause (2) or (3), remains in effect.

(e) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only if the commissioner demonstrates by a preponderance of the evidence that a criminal complaint and warrant or summons was issued for the license holder or controlling individual that was not dismissed, and that the criminal charge is an offense that involves fraud or theft against a program administered by the commissioner.

(f) For suspensions under subdivision 2, paragraph (c), the burden of proof in expedited hearings under this subdivision is met only if the commissioner demonstrates by a preponderance of the evidence that the license holder or controlling individual is the subject of a pending administrative, civil, or criminal investigation or is subject to an administrative or civil action related to fraud against a program administered by a state or federal agency.

Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules including but not limited to the requirements of this chapter and chapter 245C;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has been disqualified and the disqualification was not set aside and no variance has been granted;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules;

106.1 (4) a license holder is excluded from any program administered by the commissioner
106.2 under section 245.095;

106.3 (5) revocation is required under section 245A.04, subdivision 7, paragraph (d); or

106.4 (6) suspension is necessary under subdivision 2a, paragraph (b), clause (2) or (3).

106.5 A license holder who has had a license issued under this chapter suspended, revoked,
106.6 or has been ordered to pay a fine must be given notice of the action by certified mail, by
106.7 personal service, or through the provider licensing and reporting hub. If mailed, the notice
106.8 must be mailed to the address shown on the application or the last known address of the
106.9 license holder. The notice must state in plain language the reasons the license was suspended
106.10 or revoked, or a fine was ordered.

106.11 (b) If the license was suspended or revoked, the notice must inform the license holder
106.12 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
106.13 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
106.14 a license. The appeal of an order suspending or revoking a license must be made in writing
106.15 by certified mail, by personal service, or through the provider licensing and reporting hub.
106.16 If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
106.17 days after the license holder receives notice that the license has been suspended or revoked.
106.18 If a request is made by personal service, it must be received by the commissioner within
106.19 ten calendar days after the license holder received the order. If the order is issued through
106.20 the provider hub, the appeal must be received by the commissioner within ten calendar days
106.21 from the date the commissioner issued the order through the hub. Except as provided in
106.22 subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order
106.23 suspending or revoking a license, the license holder may continue to operate the program
106.24 as provided in section 245A.04, subdivision 7, paragraphs (i) and (j), until the commissioner
106.25 issues a final order on the suspension or revocation.

106.26 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license
106.27 holder of the responsibility for payment of fines and the right to a contested case hearing
106.28 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an
106.29 order to pay a fine must be made in writing by certified mail, by personal service, or through
106.30 the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent
106.31 to the commissioner within ten calendar days after the license holder receives notice that
106.32 the fine has been ordered. If a request is made by personal service, it must be received by
106.33 the commissioner within ten calendar days after the license holder received the order. If the

107.1 order is issued through the provider hub, the appeal must be received by the commissioner
107.2 within ten calendar days from the date the commissioner issued the order through the hub.

107.3 (2) The license holder shall pay the fines assessed on or before the payment date specified.
107.4 If the license holder fails to fully comply with the order, the commissioner may issue a
107.5 second fine or suspend the license until the license holder complies. If the license holder
107.6 receives state funds, the state, county, or municipal agencies or departments responsible for
107.7 administering the funds shall withhold payments and recover any payments made while the
107.8 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine
107.9 until the commissioner issues a final order.

107.10 (3) A license holder shall promptly notify the commissioner of human services, in writing,
107.11 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the
107.12 commissioner determines that a violation has not been corrected as indicated by the order
107.13 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify
107.14 the license holder by certified mail, by personal service, or through the provider licensing
107.15 and reporting hub that a second fine has been assessed. The license holder may appeal the
107.16 second fine as provided under this subdivision.

107.17 (4) Fines shall be assessed as follows:

107.18 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
107.19 child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557
107.20 for which the license holder is determined responsible for the maltreatment under section
107.21 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

107.22 (ii) if the commissioner determines that a determination of maltreatment for which the
107.23 license holder is responsible is the result of maltreatment that meets the definition of serious
107.24 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
107.25 \$5,000;

107.26 (iii) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule
107.27 governing matters of health, safety, or supervision, including but not limited to the provision
107.28 of adequate staff-to-child or adult ratios, and failure to comply with background study
107.29 requirements under chapter 245C; and

107.30 (iv) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule
107.31 other than those subject to a \$5,000, \$1,000, or \$200 fine in items (i) to (iii).

107.32 For purposes of this section, "occurrence" means each violation identified in the
107.33 commissioner's fine order. Fines assessed against a license holder that holds a license to

provide home and community-based services, as identified in section 245D.03, subdivision 1, and a community residential setting or day services facility license under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

Sec. 9. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, ~~shall~~ must pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to \$10,000	\$250
greater than \$10,000 but less than or equal to \$25,000	\$375
greater than \$25,000 but less than or equal to \$50,000	\$500
greater than \$50,000 but less than or equal to \$100,000	\$625
greater than \$100,000 but less than or equal to \$150,000	\$750

109.1	greater than \$150,000 but less than or	
109.2	equal to \$200,000	\$1,000
109.3	greater than \$200,000 but less than or	
109.4	equal to \$250,000	\$1,250
109.5	greater than \$250,000 but less than or	
109.6	equal to \$300,000	\$1,500
109.7	greater than \$300,000 but less than or	
109.8	equal to \$350,000	\$1,750
109.9	greater than \$350,000 but less than or	
109.10	equal to \$400,000	\$2,000
109.11	greater than \$400,000 but less than or	
109.12	equal to \$450,000	\$2,250
109.13	greater than \$450,000 but less than or	
109.14	equal to \$500,000	\$2,500
109.15	greater than \$500,000 but less than or	
109.16	equal to \$600,000	\$2,850
109.17	greater than \$600,000 but less than or	
109.18	equal to \$700,000	\$3,200
109.19	greater than \$700,000 but less than or	
109.20	equal to \$800,000	\$3,600
109.21	greater than \$800,000 but less than or	
109.22	equal to \$900,000	\$3,900
109.23	greater than \$900,000 but less than or	
109.24	equal to \$1,000,000	\$4,250
109.25	greater than \$1,000,000 but less than or	
109.26	equal to \$1,250,000	\$4,550
109.27	greater than \$1,250,000 but less than or	
109.28	equal to \$1,500,000	\$4,900
109.29	greater than \$1,500,000 but less than or	
109.30	equal to \$1,750,000	\$5,200
109.31	greater than \$1,750,000 but less than or	
109.32	equal to \$2,000,000	\$5,500
109.33	greater than \$2,000,000 but less than or	
109.34	equal to \$2,500,000	\$5,900
109.35	greater than \$2,500,000 but less than or	
109.36	equal to \$3,000,000	\$6,200
109.37	greater than \$3,000,000 but less than or	
109.38	equal to \$3,500,000	\$6,500
109.39	greater than \$3,500,000 but less than or	
109.40	equal to \$4,000,000	\$7,200
109.41	greater than \$4,000,000 but less than or	
109.42	equal to \$4,500,000	\$7,800
109.43	greater than \$4,500,000 but less than or	
109.44	equal to \$5,000,000	\$9,000
109.45	greater than \$5,000,000 but less than or	
109.46	equal to \$7,500,000	\$10,000

110.1	greater than \$7,500,000 but less than or	
110.2	equal to \$10,000,000	\$14,000
110.3	greater than \$10,000,000 but less than or	
110.4	equal to \$12,500,000	\$18,000
110.5	greater than \$12,500,000 but less than or	
110.6	equal to \$15,000,000	\$25,000
110.7	greater than \$15,000,000 but less than or	
110.8	equal to \$17,500,000	\$28,000
110.9	greater than \$17,500,000 but less than <u>or</u>	
110.10	<u>equal to</u> \$20,000,000	\$32,000
110.11	greater than \$20,000,000 but less than <u>or</u>	
110.12	<u>equal to</u> \$25,000,000	\$36,000
110.13	greater than \$25,000,000 but less than <u>or</u>	
110.14	<u>equal to</u> \$30,000,000	\$45,000
110.15	greater than \$30,000,000 but less than <u>or</u>	
110.16	<u>equal to</u> \$35,000,000	\$55,000
110.17	greater than \$35,000,000	\$75,000

110.18 (2) If requested, the license holder ~~shall~~ must provide the commissioner information to
 110.19 verify the license holder's annual revenues or other information as needed, including copies
 110.20 of documents submitted to the Department of Revenue.

110.21 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,
 110.22 and not provide annual revenue information to the commissioner.

110.23 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts
 110.24 for the purpose of paying a lower license fee ~~shall~~ must be subject to a civil penalty in the
 110.25 amount of double the fee the provider should have paid.

110.26 (b) A substance use disorder treatment program licensed under chapter 245G, to provide
 110.27 substance use disorder treatment ~~shall~~ must pay an annual nonrefundable license fee based
 110.28 on the following schedule:

110.29	Licensed Capacity	License Fee
110.30	1 to 24 persons	\$2,600
110.31	25 to 49 persons	\$3,000
110.32	50 to 74 persons	\$5,000
110.33	75 to 99 persons	\$10,000
110.34	100 to 199 persons	\$15,000
110.35	200 or more persons	\$20,000

110.36 (c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to
 110.37 9530.6590, or a withdrawal management program licensed under chapter 245F ~~shall~~ must
 110.38 pay an annual nonrefundable license fee based on the following schedule:

111.1	Licensed Capacity	License Fee
111.2	1 to 24 persons	\$2,600
111.3	25 to 49 persons	\$3,000
111.4	50 or more persons	\$5,000

111.5 A detoxification program that also operates a withdrawal management program at the same
 111.6 location ~~shall~~ must only pay one fee based upon the licensed capacity of the program with
 111.7 the higher overall capacity.

111.8 (d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to
 111.9 serve children shall pay an annual nonrefundable license fee based on the following schedule:

111.10	Licensed Capacity	License Fee
111.11	1 to 24 persons	\$1,000
111.12	25 to 49 persons	\$1,100
111.13	50 to 74 persons	\$1,200
111.14	75 to 99 persons	\$1,300
111.15	100 or more persons	\$1,400

111.16 (e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
 111.17 9520.0500 to 9520.0670, to serve persons with mental illness ~~shall~~ must pay an annual
 111.18 nonrefundable license fee based on the following schedule:

111.19	Licensed Capacity	License Fee
111.20	1 to 24 persons	\$2,600
111.21	25 to 49 persons	\$3,000
111.22	50 or more persons	\$20,000

111.23 (f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 111.24 to serve persons with physical disabilities ~~shall~~ must pay an annual nonrefundable license
 111.25 fee based on the following schedule:

111.26	Licensed Capacity	License Fee
111.27	1 to 24 persons	\$450
111.28	25 to 49 persons	\$650
111.29	50 to 74 persons	\$850
111.30	75 to 99 persons	\$1,050
111.31	100 or more persons	\$1,250

111.32 (g) A program licensed as an adult day care center licensed under Minnesota Rules,
 111.33 parts 9555.9600 to 9555.9730, ~~shall~~ must pay an annual nonrefundable license fee based
 111.34 on the following schedule:

112.1	Licensed Capacity	License Fee
112.2	1 to 24 persons	\$2,600
112.3	25 to 49 persons	\$3,000
112.4	50 to 74 persons	\$5,000
112.5	75 to 99 persons	\$10,000
112.6	100 to 199 persons	\$15,000
112.7	200 or more persons	\$20,000

112.8 (h) A program licensed to provide treatment services to persons with sexual psychopathic
 112.9 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
 112.10 9515.3110, ~~shall~~ must pay an annual nonrefundable license fee of \$20,000.

112.11 (i) A mental health clinic certified under section 245I.20 ~~shall~~ must pay an annual
 112.12 nonrefundable certification fee of \$1,550. If the mental health clinic provides services at a
 112.13 primary location with satellite facilities, the satellite facilities ~~shall~~ must be certified with
 112.14 the primary location without an additional charge.

112.15 (j) If a program subject to annual fees under paragraph (b) provides services at a primary
 112.16 location with satellite facilities, the satellite facilities must be licensed with the primary
 112.17 location and must be subject to an additional \$500 annual nonrefundable license fee per
 112.18 satellite facility.

112.19 Sec. 10. Minnesota Statutes 2025 Supplement, section 245A.142, subdivision 3, is amended
 112.20 to read:

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

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

112.27 (c) Beginning June 1, 2026, an agency must not operate if it has not submitted an
 112.28 application for provisional licensure under this section. The commissioner shall disenroll
 112.29 an agency from providing EIDBI services under chapter 256B if the agency fails to submit
 112.30 an application for provisional licensure by May 31, 2026.

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

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

(f) Initial provisional license applications are subject to the application fee under section 245A.10, subdivision 3, paragraph (a).

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

Sec. 11. Minnesota Statutes 2025 Supplement, section 245A.242, subdivision 2, is amended to read:

Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency treatment of opioid overdose ~~and~~. For administration via intramuscular injection, a license holder must have a written standing order protocol by a physician who is licensed under chapter 147, advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of intramuscular injection opiate antagonists on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both, before the staff has direct contact, as defined in section 245C.02, subdivision 11, with a person served by the program.

(b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

(1) emergency opiate antagonist medications are not required to be stored in a locked area and staff and adult clients may carry this medication on them and store it in an unlocked location;

(2) staff persons who only administer emergency opiate antagonist medications only require the training required by paragraph (a), which any knowledgeable trainer may provide. The trainer is not required to be a registered nurse or part of an accredited educational institution; and

(3) nonresidential substance use disorder treatment programs that do not administer client medications beyond emergency opiate antagonist medications are not required to have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and must instead describe the program's procedures for administering opiate antagonist medications in the license holder's description of health care services under section 245G.08, subdivision 1.

114.1 Sec. 12. Minnesota Statutes 2024, section 245C.02, subdivision 18, is amended to read:

114.2 Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse,
114.3 maltreatment resulting in death, neglect resulting in serious injury which reasonably requires
114.4 the care of a physician, advanced practice registered nurse, or physician assistant whether
114.5 or not the care of a physician, advanced practice registered nurse, or physician assistant was
114.6 sought, ~~or~~ abuse resulting in serious injury, or financial exploitation of a vulnerable adult
114.7 if the value of the funds or property is \$1,000 or greater.

114.8 (b) For purposes of this definition, "care of a physician, advanced practice registered
114.9 nurse, or physician assistant" is treatment received or ordered by a physician, physician
114.10 assistant, or advanced practice registered nurse, but does not include:

114.11 (1) diagnostic testing, assessment, or observation;

114.12 (2) the application of, recommendation to use, or prescription solely for a remedy that
114.13 is available over the counter without a prescription; or

114.14 (3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up
114.15 appointment.

114.16 (c) For purposes of this definition, "abuse resulting in serious injury" means: bruises,
114.17 bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries;
114.18 head injuries with loss of consciousness; extensive second-degree or third-degree burns and
114.19 other burns for which complications are present; extensive second-degree or third-degree
114.20 frostbite and other frostbite for which complications are present; irreversible mobility or
114.21 avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are
114.22 harmful; near drowning; and heat exhaustion or sunstroke.

114.23 (d) Serious maltreatment includes neglect when it results in criminal sexual conduct
114.24 against a child or vulnerable adult.

114.25 Sec. 13. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

114.26 Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall
114.27 conduct a background study on:

114.28 (1) the person or persons applying for a license;

114.29 (2) an individual age 13 and over living in the household where the licensed program
114.30 will be provided who is not receiving licensed services from the program;

114.31 (3) current or prospective employees of the applicant or license holder who will have
114.32 direct contact with persons served by the facility, agency, or program;

115.1 (4) volunteers or student volunteers who will have direct contact with persons served
115.2 by the program to provide program services if the contact is not under the continuous, direct
115.3 supervision by an individual listed in clause (1) or (3);

115.4 (5) an individual age ten to 12 living in the household where the licensed services will
115.5 be provided when the commissioner has reasonable cause as defined in section 245C.02,
115.6 subdivision 15;

115.7 (6) an individual who, without providing direct contact services at a licensed program,
115.8 may have unsupervised access to children or vulnerable adults receiving services from a
115.9 program, when the commissioner has reasonable cause as defined in section 245C.02,
115.10 subdivision 15; and

115.11 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

115.12 (8) notwithstanding clause (3), for children's residential facilities and foster residence
115.13 settings, any adult working in the facility, whether or not the individual will have direct
115.14 contact with persons served by the facility.

115.15 (b) For child foster care when the license holder resides in the home where foster care
115.16 services are provided, a short-term substitute caregiver providing direct contact services for
115.17 a child for less than 72 hours of continuous care is not required to receive a background
115.18 study under this chapter.

115.19 (c) This subdivision applies to the following programs that must be licensed under
115.20 chapter 245A:

115.21 (1) adult foster care;

115.22 (2) children's residential facilities;

115.23 (3) licensed home and community-based services under chapter 245D;

115.24 (4) residential mental health programs for adults;

115.25 (5) substance use disorder treatment programs under chapter 245G;

115.26 (6) withdrawal management programs under chapter 245F;

115.27 (7) adult day care centers;

115.28 (8) family adult day services;

115.29 (9) detoxification programs;

115.30 (10) community residential settings;

(11) intensive residential treatment services and residential crisis stabilization under chapter 245I; ~~and~~

(12) treatment programs for persons with sexual psychopathic personality or sexually dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts 9515.3000 to 9515.3110-; and

(13) children's foster residence settings.

EFFECTIVE DATE. This section is effective November 3, 2026.

Sec. 14. Minnesota Statutes 2024, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care background study subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. Except as provided in section 245C.05, subdivision 5a, a child care background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.

(c) At reauthorization or when a new background study is needed under section 142E.16, subdivision 2, for a legal nonlicensed child care provider authorized under chapter 142E:

(1) for a background study affiliated with a legal nonlicensed child care provider, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the commissioner and be fingerprinted and photographed under section 245C.05, subdivision 5; and

(2) the commissioner shall verify the information received under clause (1) and submit the request in NETStudy 2.0 to complete the background study.

(d) At reapplication for a family child care license:

(1) for a background study affiliated with a licensed family child care center, the individual shall provide information required under section 245C.05, subdivision 1,

117.1 paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed
117.2 under section 245C.05, subdivision 5;

117.3 (2) the county agency shall verify the information received under clause (1) and forward
117.4 the information to the commissioner and submit the request in NETStudy 2.0 to complete
117.5 the background study; and

117.6 (3) the background study conducted by the commissioner under this paragraph must
117.7 include a review of the information required under section 245C.08.

117.8 ~~(e) The commissioner is not required to conduct a study of an individual at the time of~~
117.9 ~~reapplication for a license if the individual's background study was completed by the~~
117.10 ~~commissioner of human services and the following conditions are met:~~

117.11 ~~(1) a study of the individual was conducted either at the time of initial licensure or when~~
117.12 ~~the individual became affiliated with the license holder;~~

117.13 ~~(2) the individual has been continuously affiliated with the license holder since the last~~
117.14 ~~study was conducted; and~~

117.15 ~~(3) the last study of the individual was conducted on or after October 1, 1995.~~

117.16 ~~(f)~~ (e) The commissioner of human services shall conduct a background study of an
117.17 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6),
117.18 who is newly affiliated, or currently affiliated without a background study that was submitted
117.19 through the electronic system known as NETStudy 2.0, with a child foster family setting
117.20 license holder:

117.21 (1) the county or private agency shall collect and forward to the commissioner the
117.22 information required under section 245C.05, subdivisions 1 and 5, when the child foster
117.23 family setting applicant or license holder resides in the home where child foster care services
117.24 are provided; and

117.25 (2) the background study conducted by the commissioner of human services under this
117.26 paragraph must include a review of the information required under section 245C.08,
117.27 subdivisions 1, 3, and 4.

117.28 ~~(g)~~ (f) The commissioner shall conduct a background study of an individual specified
117.29 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly
117.30 affiliated, or currently affiliated without a background study that was submitted through the
117.31 electronic system known as NETStudy 2.0, with an adult foster care or family adult day
117.32 services and with a family child care license holder or a legal nonlicensed child care provider
117.33 authorized under chapter 142E and:

(1) except as provided in section 245C.05, subdivision 5a, the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraph (b), for background studies conducted by the commissioner for all family adult day services, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 142E;

(2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

~~(h)~~ (g) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy 2.0 before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(i)~~ (h) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

~~(j)~~ (i) For purposes of this section, a physician licensed under chapter 147, advanced practice registered nurse licensed under chapter 148, or physician assistant licensed under chapter 147A is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's, advanced practice registered nurse's, or physician assistant's background study results.

119.1 ~~(k)~~ (j) For purposes of family child care, a substitute caregiver must receive repeat
119.2 background studies at the time of each license renewal.

119.3 ~~(H)~~ (k) A repeat background study at the time of license renewal is not required if the
119.4 family child care substitute caregiver's background study was completed by the commissioner
119.5 on or after October 1, 2017, and the substitute caregiver is on the license holder's active
119.6 roster in NETStudy 2.0.

119.7 ~~(m)~~ (l) Before and after school programs authorized under chapter 142E, are exempt
119.8 from the background study requirements under section 123B.03, for an employee for whom
119.9 a background study under this chapter has been completed.

119.10 Sec. 15. Minnesota Statutes 2025 Supplement, section 245C.07, is amended to read:

119.11 **245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.**

119.12 (a) Subject to the conditions in paragraph (d), when a license holder, applicant, or other
119.13 entity owns multiple programs or services that are licensed by the Department of Human
119.14 Services; Department of Children, Youth, and Families; Department of Health; or Department
119.15 of Corrections, only one background study is required for an individual who provides direct
119.16 contact services in one or more of the licensed programs or services if:

119.17 (1) the license holder designates one individual with one address and telephone number
119.18 as the person to receive sensitive background study information for the multiple licensed
119.19 programs or services that depend on the same background study; and

119.20 (2) the individual designated to receive the sensitive background study information is
119.21 capable of determining, upon request of the department, whether a background study subject
119.22 is providing direct contact services in one or more of the license holder's programs or services
119.23 and, if so, at which location or locations.

119.24 (b) When a license holder maintains background study compliance for multiple licensed
119.25 programs according to paragraph (a), and one or more of the licensed programs closes, the
119.26 license holder shall immediately notify the commissioner which staff must be transferred
119.27 to an active license so that the background studies can be electronically paired with the
119.28 license holder's active program.

119.29 (c) When a background study is being initiated by a licensed program or service or a
119.30 foster care provider that is also licensed under chapter 144G, a study subject affiliated with
119.31 multiple licensed programs or services may attach to the background study form a cover
119.32 letter indicating the additional names of the programs or services, addresses, and background
119.33 study identification numbers.

120.1 When the commissioner receives a notice, the commissioner shall notify each program
120.2 or service identified by the background study subject of the study results.

120.3 The background study notice the commissioner sends to the subsequent agencies shall
120.4 satisfy those programs' or services' responsibilities for initiating a background study on that
120.5 individual.

120.6 ~~(d) If a background study was conducted on an individual related to child foster care~~
120.7 ~~and the requirements under paragraph (a) are met, the background study is transferable~~
120.8 ~~across all licensed programs.~~ If a background study was conducted on an individual under
120.9 a license other than child foster care and the requirements under paragraph (a) are met, the
120.10 background study is transferable to all licensed programs except child foster care.

120.11 (e) The provisions of this section that allow a single background study in one or more
120.12 licensed programs or services do not apply to background studies submitted by adoption
120.13 agencies, supplemental nursing services agencies, personnel pool agencies, educational
120.14 programs, professional services agencies, temporary personnel agencies, and unlicensed
120.15 personal care provider organizations.

120.16 (f) For an entity operating under NETStudy 2.0, the entity's active roster must be the
120.17 system used to document when a background study subject is affiliated with multiple entities.
120.18 For a background study to be transferable:

120.19 (1) the background study subject must be on and moving to a roster for which the person
120.20 designated to receive sensitive background study information is the same; and

120.21 (2) the same entity must own or legally control both the roster from which the transfer
120.22 is occurring and the roster to which the transfer is occurring. For an entity that holds or
120.23 controls multiple licenses, or unlicensed personal care provider organizations, there must
120.24 be a common highest level entity that has a legally identifiable structure that can be verified
120.25 through records available from the secretary of state.

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

120.27 Sec. 16. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended
120.28 to read:

120.29 Subd. 2. **Activities pending completion of background study.** The subject of a
120.30 background study may not perform any activity requiring a background study under
120.31 paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

120.32 (a) Notices from the commissioner required prior to activity under paragraph (c) include:

121.1 (1) a notice of the study results under section 245C.17 stating that:

121.2 (i) the individual is not disqualified; or

121.3 (ii) more time is needed to complete the study but the individual is not required to be
121.4 removed from direct contact or access to people receiving services prior to completion of
121.5 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
121.6 that more time is needed to complete the study must also indicate whether the individual is
121.7 required to be under continuous direct supervision prior to completion of the background
121.8 study. When more time is necessary to complete a background study of an individual
121.9 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,
121.10 the individual may not work in the facility or setting regardless of whether or not the
121.11 individual is supervised;

121.12 (2) a notice that a disqualification has been set aside under section 245C.23; or

121.13 (3) a notice that a variance has been granted related to the individual under section
121.14 245C.30.

121.15 (b) For a child care background study ~~affiliated with a licensed child care center or~~
121.16 ~~certified license-exempt child care center~~ subject required to submit fingerprints for a
121.17 national criminal history check, except as provided in section 245C.05, subdivision 5a, the
121.18 notice sent under paragraph (a), clause (1), item (ii), must not be issued until the
121.19 commissioner receives a qualifying result for the individual for the fingerprint-based national
121.20 criminal history record check or the fingerprint-based criminal history information from
121.21 the Bureau of Criminal Apprehension. The notice must require the individual to be under
121.22 continuous direct supervision prior to completion of the remainder of the background study
121.23 except as permitted in subdivision 3.

121.24 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

121.25 (1) being issued a license;

121.26 (2) living in the household where the licensed program will be provided;

121.27 (3) providing direct contact services to persons served by a program unless the subject
121.28 is under continuous direct supervision;

121.29 (4) having access to persons receiving services if the background study was completed
121.30 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),
121.31 (5), or (6), unless the subject is under continuous direct supervision;

122.1 (5) ~~for licensed child care centers and certified license-exempt child care centers~~ a child
122.2 care background study subject, providing direct contact services to persons served by the
122.3 program performing any act listed in section 245C.02, subdivision 6a, unless the study is
122.4 being renewed under section 245C.04, subdivision 1, paragraph (b), and it has been less
122.5 than five years since the child care background study subject was previously disqualified
122.6 or provided notice under paragraph (a), clause (1), item (i);

122.7 (6) for children's residential facilities or foster residence settings, working in the facility
122.8 or setting;

122.9 (7) for background studies affiliated with a personal care provider organization, except
122.10 as provided in section 245C.03, subdivision 3b, before a personal care assistant provides
122.11 services, the personal care assistance provider agency must initiate a background study of
122.12 the personal care assistant under this chapter and the personal care assistance provider
122.13 agency must have received a notice from the commissioner that the personal care assistant
122.14 is:

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

122.16 (ii) disqualified, but the personal care assistant has received a set aside of the
122.17 disqualification under section 245C.22; or

122.18 (8) for background studies affiliated with an early intensive developmental and behavioral
122.19 intervention provider, before an individual provides services, the early intensive
122.20 developmental and behavioral intervention provider must initiate a background study for
122.21 the individual under this chapter and the early intensive developmental and behavioral
122.22 intervention provider must have received a notice from the commissioner that the individual
122.23 is:

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

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

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

122.28 Sec. 17. Minnesota Statutes 2024, section 245C.15, subdivision 2, is amended to read:

122.29 Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14
122.30 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any,
122.31 for the offense; and (2) the individual has committed a felony-level violation of any of the
122.32 following offenses: sections 152.021, subdivision 1 or 2b, (aggravated controlled substance

123.1 crime in the first degree; sale crimes); 152.022, subdivision 1 (controlled substance crime
123.2 in the second degree; sale crimes); 152.023, subdivision 1 (controlled substance crime in
123.3 the third degree; sale crimes); 152.024, subdivision 1 (controlled substance crime in the
123.4 fourth degree; sale crimes); 256.98 (wrongfully obtaining assistance); 268.182 (fraud);
123.5 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 518B.01, subdivision 14
123.6 (violation of an order for protection); 609.165 (felon ineligible to possess firearm); 609.2112,
123.7 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223
123.8 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault
123.9 in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal
123.10 abuse of a vulnerable adult); 609.2334 (violation of an order for protection against financial
123.11 exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);
123.12 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.247,
123.13 subdivision 4 (carjacking in the third degree); 609.255 (false imprisonment); 609.2664
123.14 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn
123.15 child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671
123.16 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn
123.17 child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466
123.18 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b
123.19 (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521
123.20 (possession of shoplifting gear); 609.522 (organized retail theft); 609.525 (bringing stolen
123.21 goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535
123.22 (issuance of dishonored checks); 609.542 (illegal remunerations); 609.562 (arson in the
123.23 second degree); 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession
123.24 of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery);
123.25 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false
123.26 pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns);
123.27 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.746 (interference
123.28 with privacy); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud);
123.29 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene
123.30 materials and performances; distribution and exhibition prohibited; penalty); or 624.713
123.31 (certain persons not to possess firearms).

123.32 (b) An individual is disqualified under section 245C.14 if less than 15 years has passed
123.33 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
123.34 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

124.1 (c) An individual is disqualified under section 245C.14 if less than 15 years has passed
124.2 since the termination of the individual's parental rights under section 260C.301, subdivision
124.3 1, paragraph (b), or subdivision 3.

124.4 (d) An individual is disqualified under section 245C.14 if less than 15 years has passed
124.5 since the discharge of the sentence imposed for an offense in any other state or country, the
124.6 elements of which are substantially similar to the elements of the offenses listed in paragraph
124.7 (a) or since the termination of parental rights in any other state or country, the elements of
124.8 which are substantially similar to the elements listed in paragraph (c).

124.9 (e) If the individual studied commits one of the offenses listed in paragraph (a), but the
124.10 sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is
124.11 disqualified but the disqualification look-back period for the offense is the period applicable
124.12 to the gross misdemeanor or misdemeanor disposition.

124.13 (f) When a disqualification is based on a judicial determination other than a conviction,
124.14 the disqualification period begins from the date of the court order. When a disqualification
124.15 is based on an admission, the disqualification period begins from the date of an admission
124.16 in court. When a disqualification is based on an Alford Plea, the disqualification period
124.17 begins from the date the Alford Plea is entered in court. When a disqualification is based
124.18 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
124.19 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
124.20 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

124.21 Sec. 18. Minnesota Statutes 2024, section 245C.15, subdivision 3, is amended to read:

124.22 Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section
124.23 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed,
124.24 if any, for the offense; and (2) the individual has committed a gross misdemeanor-level
124.25 violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance);
124.26 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or
124.27 delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or
124.28 services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud);
124.29 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222
124.30 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth
124.31 degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault
124.32 in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243
124.33 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of
124.34 residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal

125.1 neglect of a vulnerable adult); 609.2334 (violation of an order for protection against financial
125.2 exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);
125.3 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275
125.4 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in
125.5 prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378
125.6 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft);
125.7 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527
125.8 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks);
125.9 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631
125.10 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72,
125.11 subdivision 3 (disorderly conduct against a vulnerable adult); 609.746 (interference with
125.12 privacy); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining credit); 609.821
125.13 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241
125.14 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293
125.15 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes
125.16 2012, section 609.21; or violation of an order for protection under section 518B.01,
125.17 subdivision 14.

125.18 (b) An individual is disqualified under section 245C.14 if less than ten years has passed
125.19 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
125.20 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

125.21 (c) An individual is disqualified under section 245C.14 if less than ten years has passed
125.22 since the discharge of the sentence imposed for an offense in any other state or country, the
125.23 elements of which are substantially similar to the elements of any of the offenses listed in
125.24 paragraph (a).

125.25 (d) If the individual studied commits one of the offenses listed in paragraph (a), but the
125.26 sentence or level of offense is a misdemeanor disposition, the individual is disqualified but
125.27 the disqualification lookback period for the offense is the period applicable to misdemeanors.

125.28 (e) When a disqualification is based on a judicial determination other than a conviction,
125.29 the disqualification period begins from the date of the court order. When a disqualification
125.30 is based on an admission, the disqualification period begins from the date of an admission
125.31 in court. When a disqualification is based on an Alford Plea, the disqualification period
125.32 begins from the date the Alford Plea is entered in court. When a disqualification is based
125.33 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
125.34 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
125.35 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

126.1 Sec. 19. Minnesota Statutes 2024, section 245C.15, subdivision 4, is amended to read:

126.2 Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section
126.3 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed,
126.4 if any, for the offense; and (2) the individual has committed a misdemeanor-level violation
126.5 of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425
126.6 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency);
126.7 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182
126.8 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113,
126.9 or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree);
126.10 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231
126.11 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic
126.12 assault); 609.2334 (violation of an order for protection against financial exploitation of a
126.13 vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure
126.14 to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the
126.15 third degree); 609.27 (coercion); violation of an order for protection under 609.3232
126.16 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud);
126.17 609.52 (theft); 609.522 (organized retail theft); 609.525 (bringing stolen goods into
126.18 Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance
126.19 of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665
126.20 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone
126.21 calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining
126.22 credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving
126.23 a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or
126.24 Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section
126.25 518B.01 (Domestic Abuse Act).

126.26 (b) An individual is disqualified under section 245C.14 if less than seven years has
126.27 passed since a determination or disposition of the individual's:

126.28 (1) failure to make required reports under section 260E.06 or 626.557, subdivision 3,
126.29 for incidents in which: (i) the final disposition under section 626.557 or chapter 260E was
126.30 substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

126.31 (2) substantiated serious or recurring maltreatment of a minor under chapter 260E, a
126.32 vulnerable adult under section 626.557, or serious or recurring maltreatment in any other
126.33 state, the elements of which are substantially similar to the elements of maltreatment under
126.34 section 626.557 or chapter 260E for which: (i) there is a preponderance of evidence that
126.35 the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes.

(d) An individual is disqualified under section 245C.14 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(f) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual was disqualified under section 256.98, subdivision 8.

Sec. 20. Minnesota Statutes 2025 Supplement, section 245C.15, subdivision 4a, is amended to read:

Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family foster setting, regardless of how much time has passed, an individual is disqualified under section 245C.14 if the individual committed an act that resulted in a felony-level conviction for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245 (aggravated robbery); 609.247, subdivision 2 or 3 (carjacking in the first or second degree); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661

128.1 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the
128.2 second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664
128.3 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn
128.4 child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671
128.5 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn
128.6 child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and
128.7 promotion of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other
128.8 prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution);
128.9 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in
128.10 the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal
128.11 sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree);
128.12 609.3453 (criminal sexual predatory conduct); 609.3458 (sexual extortion); 609.352
128.13 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a
128.14 child); 609.3775 (child torture); 609.378 (neglect or endangerment of a child); 609.561
128.15 (arson in the first degree); 609.582, subdivision 1 (burglary in the first degree); 609.746
128.16 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of minors in sexual
128.17 performance prohibited); or 617.247 (possession of child sexual abuse material).

128.18 (b) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for the purposes of a background
128.19 study affiliated with a licensed family foster setting, an individual is disqualified under
128.20 section 245C.14, regardless of how much time has passed, if the individual:

128.21 (1) committed an action under paragraph (e) that resulted in death or involved sexual
128.22 abuse, as defined in section 260E.03, subdivision 20;

128.23 (2) committed an act that resulted in a gross misdemeanor-level conviction for section
128.24 609.3451 (criminal sexual conduct in the fifth degree);

128.25 (3) committed an act against or involving a minor that resulted in a felony-level conviction
128.26 for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the
128.27 third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree);
128.28 or

128.29 (4) committed an act that resulted in a misdemeanor or gross misdemeanor-level
128.30 conviction for section 617.293 (dissemination and display of harmful materials to minors).

128.31 (c) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated
128.32 with a licensed family foster setting, an individual is disqualified under section 245C.14 if
128.33 fewer than 20 years have passed since the termination of the individual's parental rights
128.34 under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a

129.1 termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle
129.2 a petition to involuntarily terminate parental rights. An individual is disqualified under
129.3 section 245C.14 if fewer than 20 years have passed since the termination of the individual's
129.4 parental rights in any other state or country, where the conditions for the individual's
129.5 termination of parental rights are substantially similar to the conditions in section 260C.301,
129.6 subdivision 1, paragraph (b).

129.7 (d) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated
129.8 with a licensed family foster setting, an individual is disqualified under section 245C.14 if
129.9 fewer than five years have passed since a felony-level violation for sections: 152.021
129.10 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the
129.11 second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled
129.12 substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth
129.13 degree); 152.0261 (importing controlled substances across state borders); 152.0262,
129.14 subdivision 1, paragraph (b) (possession of substance with intent to manufacture
129.15 methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic
129.16 cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances);
129.17 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities);
129.18 152.137 (fentanyl- and methamphetamine-related crimes involving children or vulnerable
129.19 adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory
129.20 offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm);
129.21 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused
129.22 by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in
129.23 the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure
129.24 or facilitate a crime); 609.24 (simple robbery); 609.247, subdivision 4 (carjacking in the
129.25 third degree); 609.322, subdivision 1a (solicitation, inducement, and promotion of
129.26 prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with
129.27 a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness
129.28 tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree);
129.29 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons);
129.30 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5
129.31 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public
129.32 transit vehicle or facility); or 624.713 (certain people not to possess firearms).

129.33 (e) Notwithstanding subdivisions 1 to 4, 4b, and 4c, except as provided in paragraph
129.34 (a), for a background study affiliated with a licensed family child foster care license, an
129.35 individual is disqualified under section 245C.14 if fewer than five years have passed since:

130.1 (1) a felony-level violation for an act not against or involving a minor that constitutes:
130.2 section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third
130.3 degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the
130.4 fifth degree);

130.5 (2) a violation of an order for protection under section 518B.01, subdivision 14;

130.6 (3) a determination or disposition of the individual's failure to make required reports
130.7 under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition
130.8 under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment
130.9 was recurring or serious;

130.10 (4) a determination or disposition of the individual's substantiated serious or recurring
130.11 maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or
130.12 serious or recurring maltreatment in any other state, the elements of which are substantially
130.13 similar to the elements of maltreatment under chapter 260E or section 626.557 and meet
130.14 the definition of serious maltreatment or recurring maltreatment;

130.15 (5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in
130.16 the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect);
130.17 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child);
130.18 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

130.19 (6) committing an act against or involving a minor that resulted in a misdemeanor-level
130.20 violation of section 609.224, subdivision 1 (assault in the fifth degree).

130.21 (f) For purposes of this subdivision, the disqualification begins from:

130.22 (1) the date of the alleged violation, if the individual was not convicted;

130.23 (2) the date of conviction, if the individual was convicted of the violation but not
130.24 committed to the custody of the commissioner of corrections; or

130.25 (3) the date of release from prison, if the individual was convicted of the violation and
130.26 committed to the custody of the commissioner of corrections.

130.27 Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation
130.28 of the individual's supervised release, the disqualification begins from the date of release
130.29 from the subsequent incarceration.

130.30 (g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the
130.31 offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
130.32 Statutes, permanently disqualifies the individual under section 245C.14. An individual is

131.1 disqualified under section 245C.14 if fewer than five years have passed since the individual's
131.2 aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs
131.3 (d) and (e).

131.4 (h) An individual's offense in any other state or country, where the elements of the
131.5 offense are substantially similar to any of the offenses listed in paragraphs (a) and (b),
131.6 permanently disqualifies the individual under section 245C.14. An individual is disqualified
131.7 under section 245C.14 if fewer than five years have passed since an offense in any other
131.8 state or country, the elements of which are substantially similar to the elements of any
131.9 offense listed in paragraphs (d) and (e).

131.10 Sec. 21. Minnesota Statutes 2025 Supplement, section 245C.22, subdivision 5, is amended
131.11 to read:

131.12 Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under
131.13 this section, the disqualified individual remains disqualified, but may hold a license and
131.14 have direct contact with or access to persons receiving services. Except as provided in
131.15 paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the
131.16 licensed program, applicant, or agency specified in the set aside notice under section 245C.23.
131.17 For personal care provider organizations, financial management services organizations,
131.18 community first services and supports organizations, unlicensed home and community-based
131.19 organizations, and consumer-directed community supports organizations, the commissioner's
131.20 set-aside may further be limited to a specific individual who is receiving services. For new
131.21 background studies required under section 245C.04, subdivision 1, paragraph ~~(h)~~ (g), if an
131.22 individual's disqualification was previously set aside for the license holder's program and
131.23 the new background study results in no new information that indicates the individual may
131.24 pose a risk of harm to persons receiving services from the license holder, the previous
131.25 set-aside shall remain in effect.

131.26 (b) If the commissioner has previously set aside an individual's disqualification for one
131.27 or more programs or agencies, and the individual is the subject of a subsequent background
131.28 study for a different program or agency, the commissioner shall determine whether the
131.29 disqualification is set aside for the program or agency that initiated the subsequent
131.30 background study. A notice of a set-aside under paragraph (c) shall be issued within 15
131.31 working days if all of the following criteria are met:

131.32 (1) the subsequent background study was initiated in connection with a program licensed
131.33 or regulated under the same provisions of law and rule for at least one program for which
131.34 the individual's disqualification was previously set aside by the commissioner;

132.1 (2) the individual is not disqualified for an offense specified in section 245C.15,
132.2 subdivision 1 or 2;

132.3 (3) the commissioner has received no new information to indicate that the individual
132.4 may pose a risk of harm to any person served by the program; and

132.5 (4) the previous set-aside was not limited to a specific person receiving services.

132.6 (c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the
132.7 substance use disorder field, if the commissioner has previously set aside an individual's
132.8 disqualification for one or more programs or agencies in the substance use disorder treatment
132.9 field, and the individual is the subject of a subsequent background study for a different
132.10 program or agency in the substance use disorder treatment field, the commissioner shall set
132.11 aside the disqualification for the program or agency in the substance use disorder treatment
132.12 field that initiated the subsequent background study when the criteria under paragraph (b),
132.13 clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified
132.14 in section 245C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued
132.15 within 15 working days.

132.16 (d) When a disqualification is set aside under paragraph (b), the notice of background
132.17 study results issued under section 245C.17, in addition to the requirements under section
132.18 245C.17, shall state that the disqualification is set aside for the program or agency that
132.19 initiated the subsequent background study. The notice must inform the individual that the
132.20 individual may request reconsideration of the disqualification under section 245C.21 on the
132.21 basis that the information used to disqualify the individual is incorrect.

132.22 Sec. 22. Minnesota Statutes 2024, section 245C.24, subdivision 2, is amended to read:

132.23 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
132.24 paragraphs (b) to ~~(g)~~ (f), the commissioner may not set aside the disqualification of any
132.25 individual disqualified pursuant to this chapter, regardless of how much time has passed,
132.26 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
132.27 1.

132.28 (b) For an individual in the substance use disorder or corrections field who was
132.29 disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose
132.30 disqualification was set aside prior to July 1, 2005, the commissioner must consider granting
132.31 a variance pursuant to section 245C.30 for the license holder for a program dealing primarily
132.32 with adults. A request for reconsideration evaluated under this paragraph must include a
132.33 letter of recommendation from the license holder that was subject to the prior set-aside

133.1 decision addressing the individual's quality of care to children or vulnerable adults and the
133.2 circumstances of the individual's departure from that service.

133.3 (c) If an individual who requires a background study for nonemergency medical
133.4 transportation services under section 245C.03, subdivision 12, was disqualified for a crime
133.5 or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have
133.6 passed since the discharge of the sentence imposed, the commissioner may consider granting
133.7 a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this
133.8 paragraph must include a letter of recommendation from the employer. This paragraph does
133.9 not apply to a person disqualified based on a violation of sections 243.166; 609.185 to
133.10 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3,
133.11 clause (1); 617.246; or 617.247.

133.12 (d) When a licensed foster care provider adopts an individual who had received foster
133.13 care services from the provider for over six months, and the adopted individual is required
133.14 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause
133.15 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30
133.16 to permit the adopted individual with a permanent disqualification to remain affiliated with
133.17 the license holder under the conditions of the variance when the variance is recommended
133.18 by the county of responsibility for each of the remaining individuals in placement in the
133.19 home and the licensing agency for the home.

133.20 (e) For an individual 18 years of age or older affiliated with a licensed family foster
133.21 setting, the commissioner must not set aside or grant a variance for the disqualification of
133.22 any individual disqualified pursuant to this chapter, regardless of how much time has passed,
133.23 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
133.24 4a, paragraphs (a) and (b).

133.25 (f) In connection with a family foster setting license, the commissioner may grant a
133.26 variance to the disqualification for an individual who is under 18 years of age at the time
133.27 the background study is submitted.

133.28 ~~(g) In connection with foster residence settings and children's residential facilities, the~~
133.29 ~~commissioner must not set aside or grant a variance for the disqualification of any individual~~
133.30 ~~disqualified pursuant to this chapter, regardless of how much time has passed, if the individual~~
133.31 ~~was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraph~~
133.32 ~~(a) or (b).~~

134.1 Sec. 23. Minnesota Statutes 2024, section 245D.04, subdivision 3, is amended to read:

134.2 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the
134.3 right to:

134.4 (1) have personal, financial, service, health, and medical information kept private, and
134.5 be advised of disclosure of this information by the license holder;

134.6 (2) access records and recorded information about the person in accordance with
134.7 applicable state and federal law, regulation, or rule;

134.8 (3) be free from maltreatment;

134.9 (4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited
134.10 procedure identified in section 245D.06, subdivision 5, or successor provisions, except for:

134.11 (i) emergency use of manual restraint to protect the person from imminent danger to self
134.12 or others according to the requirements in section 245D.061 or successor provisions; or (ii)
134.13 the use of safety interventions as part of a positive support transition plan under section
134.14 245D.06, subdivision 8, or successor provisions;

134.15 (5) receive services in a clean and safe environment when the license holder is the owner,
134.16 lessor, or tenant of the service site;

134.17 (6) be treated with courtesy and respect and receive respectful treatment of the person's
134.18 property;

134.19 (7) reasonable observance of cultural and ethnic practice and religion;

134.20 (8) be free from bias and harassment regarding race, gender, age, disability, spirituality,
134.21 and sexual orientation;

134.22 (9) be informed of and use the license holder's grievance policy and procedures, including
134.23 knowing how to contact persons responsible for addressing problems and to appeal under
134.24 section 256.045;

134.25 (10) know the name, telephone number, and the website, email, and street addresses of
134.26 protection and advocacy services, including the appropriate state-appointed ombudsman,
134.27 and a brief description of how to file a complaint with these offices;

134.28 (11) assert these rights personally, or have them asserted by the person's family,
134.29 authorized representative, or legal representative, without retaliation;

134.30 (12) give or withhold written informed consent to participate in any research or
134.31 experimental treatment;

- 135.1 (13) associate with other persons of the person's choice in the community;
- 135.2 (14) personal privacy, including the right to use the lock on the person's bedroom or unit
- 135.3 door;
- 135.4 (15) engage in chosen activities; and
- 135.5 (16) access to the person's personal possessions at any time, including financial resources.
- 135.6 (b) For a person residing in a residential site licensed according to chapter 245A, or
- 135.7 where the license holder is the owner, lessor, or tenant of the residential service site,
- 135.8 protection-related rights also include the right to:
- 135.9 (1) have daily, private access to and use of a non-coin-operated telephone for local calls
- 135.10 and long-distance calls made collect or paid for by the person;
- 135.11 (2) receive and send, without interference, uncensored, unopened mail or electronic
- 135.12 correspondence or communication;
- 135.13 (3) have use of and free access to common areas in the residence and the freedom to
- 135.14 come and go from the residence at will;
- 135.15 (4) choose the person's visitors and time of visits and have privacy for visits with the
- 135.16 person's spouse, next of kin, legal counsel, religious adviser, or others, in accordance with
- 135.17 section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;
- 135.18 (5) have access to three nutritionally balanced meals and nutritious snacks between
- 135.19 meals each day;
- 135.20 (6) have freedom and support to access food and potable water at any time;
- 135.21 (7) have the freedom to furnish and decorate the person's bedroom or living unit;
- 135.22 (8) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling
- 135.23 paint, mold, vermin, and insects;
- 135.24 (9) a setting that is free from hazards that threaten the person's health or safety; and
- 135.25 (10) a setting that meets the definition of a dwelling unit within a residential occupancy
- 135.26 as defined in the State Fire Code.
- 135.27 (c) Restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph
- 135.28 (b), clauses (1) to (7), is allowed only if determined necessary to ensure the health, safety,
- 135.29 and well-being of the person. Any restriction of those rights must be documented in the
- 135.30 person's support plan or support plan addendum. The restriction must be implemented in
- 135.31 the least restrictive alternative manner necessary to protect the person and provide support

136.1 to reduce or eliminate the need for the restriction in the most integrated setting and inclusive
136.2 manner. The documentation must include the following information:

136.3 (1) the justification for the restriction based on an assessment of the person's vulnerability
136.4 related to exercising the right without restriction;

136.5 (2) the objective measures set as conditions for ending the restriction;

136.6 (3) a schedule for reviewing the need for the restriction based on the conditions for
136.7 ending the restriction to occur semiannually from the date of initial approval, at a minimum,
136.8 or more frequently if requested by the person, the person's legal representative, if any, and
136.9 case manager; and

136.10 (4) signed and dated approval for the restriction from the person, or the person's legal
136.11 representative, if any. A restriction may be implemented only when the required approval
136.12 has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the
136.13 right must be immediately and fully restored.

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

136.15 Sec. 24. Minnesota Statutes 2024, section 245D.10, subdivision 4, is amended to read:

136.16 Subd. 4. **Availability of current written policies and procedures.** (a) The license
136.17 holder must review and update, as needed, the written policies and procedures required
136.18 under this chapter.

136.19 (b)(1) The license holder must inform the person, the person's legal representative, and
136.20 the person's case manager of the policies and procedures affecting a person's rights under
136.21 section 245D.04, and provide copies of those policies and procedures, within five working
136.22 days of service initiation.

136.23 (2) If a license holder only provides basic services and supports, this includes the:

136.24 (i) grievance policy and procedure required under subdivision 2; ~~and~~

136.25 (ii) service suspension and termination policy and procedure required under subdivision
136.26 3; ~~and~~

136.27 (iii) emergency use of manual restraints policy and procedure required under section
136.28 245D.061, subdivision 9, or successor provisions.

136.29 (3) For all other license holders this includes the:

136.30 (i) policies and procedures in clause (2); and

137.1 ~~(ii) emergency use of manual restraints policy and procedure required under section~~
137.2 ~~245D.061, subdivision 9, or successor provisions; and~~

137.3 ~~(iii)~~ (ii) data privacy requirements under section 245D.11, subdivision 3.

137.4 (c) The license holder must provide a written notice to all persons or their legal
137.5 representatives and case managers at least 30 days before implementing any procedural
137.6 revisions to policies affecting a person's service-related or protection-related rights under
137.7 section 245D.04 and maltreatment reporting policies and procedures. The notice must
137.8 explain the revision that was made and include a copy of the revised policy and procedure.
137.9 The license holder must document the reasonable cause for not providing the notice at least
137.10 30 days before implementing the revisions.

137.11 (d) Before implementing revisions to required policies and procedures, the license holder
137.12 must inform all employees of the revisions and provide training on implementation of the
137.13 revised policies and procedures.

137.14 (e) The license holder must annually notify all persons, or their legal representatives,
137.15 and case managers of any procedural revisions to policies required under this chapter, other
137.16 than those in paragraph (c). Upon request, the license holder must provide the person, or
137.17 the person's legal representative, and case manager with copies of the revised policies and
137.18 procedures.

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

137.20 Sec. 25. Minnesota Statutes 2024, section 256B.02, is amended by adding a subdivision
137.21 to read:

137.22 Subd. 20. **Fraud.** "Fraud" means an intentional deception or misrepresentation made by
137.23 a person with the knowledge that the deception could result in an unauthorized benefit to
137.24 the person or another person or an act, promise to act, or omission made with the intent to
137.25 obtain a benefit in a manner that is prohibited. Fraud includes:

137.26 (1) submitting an application for provider status knowing that the application
137.27 misrepresents, conceals, or fails to disclose any material information;

137.28 (2) intentionally submitting a claim for reimbursement under this chapter, knowing or
137.29 having reason to know the claim is ineligible for reimbursement in whole or in part;

137.30 (3) providing documentation or other information requested by the commissioner having
137.31 knowledge that it is false in any material respect; and

138.1 (4) any act that constitutes the commission, or attempt or conspiracy to commit, a
 138.2 violation of any of the following:

138.3 (i) section 256.98 (wrongfully obtaining assistance);

138.4 (ii) section 609.466 (medical assistance fraud);

138.5 (iii) section 609.48 (perjury), involving making a false statement related to medical
 138.6 assistance or the receipt of public money;

138.7 (iv) section 609.496 (concealing criminal proceeds) or 609.497 (engaging in business
 138.8 of concealing criminal proceeds), involving proceeds consisting of public money;

138.9 (v) section 609.52 (theft), involving theft of property consisting of public money;

138.10 (vi) section 609.542 (illegal remuneration);

138.11 (vii) section 609.625 (aggravated forgery) or 609.63 (forgery), involving falsely filing
 138.12 any record, account, or other document with any state agency or department or falsely
 138.13 making or altering any record, account, or other document filed with any state agency or
 138.14 department;

138.15 (viii) section 609.821 (financial transaction card fraud), involving a public assistance
 138.16 benefit;

138.17 (ix) a felony listed in United States Code, title 42, section 1320a-7b(b)(1) or (2), subject
 138.18 to any safe harbors established in Code of Federal Regulations, title 42, section 1001.952;
 138.19 and

138.20 (x) any other act that constitutes fraud under applicable federal law.

138.21 Sec. 26. Minnesota Statutes 2024, section 256B.04, subdivision 10, is amended to read:

138.22 Subd. 10. **Investigation of certain claims.** The commissioner must establish by rule
 138.23 general criteria and procedures for the identification and prompt investigation of suspected
 138.24 medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment
 138.25 of claims for services not reasonable or medically necessary, or false statement or
 138.26 representation of material facts by a vendor of medical care, ~~and for the imposition of~~
 138.27 ~~sanctions against a vendor of medical care.~~ The commissioner may use both prepayment
 138.28 and postpayment review systems to review claims submitted by vendors. Payment of claims,
 138.29 including payments made after a prepayment review, does not prohibit the commissioner
 138.30 from completing a postpayment claims review and taking additional administrative actions
 138.31 or monetary recovery against a vendor. If it appears to the state agency that a vendor of

139.1 medical care may have acted in a manner warranting civil or criminal proceedings, it shall
139.2 so inform the attorney general in writing.

139.3 Sec. 27. Minnesota Statutes 2025 Supplement, section 256B.0659, subdivision 21, is
139.4 amended to read:

139.5 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
139.6 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
139.7 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
139.8 a format determined by the commissioner, information and documentation that includes,
139.9 but is not limited to, the following:

139.10 (1) the personal care assistance provider agency's current contact information including
139.11 address, telephone number, and email address;

139.12 (2) proof of surety bond coverage for each business location providing services. Upon
139.13 new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up
139.14 to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If
139.15 the Medicaid revenue in the previous year is over \$300,000, the provider agency must
139.16 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the
139.17 commissioner, must be ~~renewed~~ purchased new annually, and must allow for recovery of
139.18 costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or
139.19 sanctions from a surety bond must occur within six years from the date the debt is affirmed
139.20 by a final agency decision. An agency decision is final when the right to appeal the debt
139.21 has been exhausted or the time to appeal has expired under section 256B.064;

139.22 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location
139.23 providing service;

139.24 (4) proof of workers' compensation insurance coverage identifying the business location
139.25 where personal care assistance services are provided;

139.26 (5) proof of liability insurance coverage identifying the business location where personal
139.27 care assistance services are provided and naming the department as a certificate holder;

139.28 (6) a copy of the personal care assistance provider agency's written policies and
139.29 procedures including: hiring of employees; training requirements; service delivery; and
139.30 employee and consumer safety including process for notification and resolution of consumer
139.31 grievances, identification and prevention of communicable diseases, and employee
139.32 misconduct;

140.1 (7) copies of all other forms the personal care assistance provider agency uses in the
140.2 course of daily business including, but not limited to:

140.3 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
140.4 varies from the standard time sheet for personal care assistance services approved by the
140.5 commissioner, and a letter requesting approval of the personal care assistance provider
140.6 agency's nonstandard time sheet;

140.7 (ii) the personal care assistance provider agency's template for the personal care assistance
140.8 care plan; and

140.9 (iii) the personal care assistance provider agency's template for the written agreement
140.10 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

140.11 (8) a list of all training and classes that the personal care assistance provider agency
140.12 requires of its staff providing personal care assistance services;

140.13 (9) documentation that the personal care assistance provider agency and staff have
140.14 successfully completed all the training required by this section, including the requirements
140.15 under subdivision 11, paragraph (d), if enhanced personal care assistance services are
140.16 provided and submitted for an enhanced rate under subdivision 17a;

140.17 (10) documentation of the agency's marketing practices;

140.18 (11) disclosure of ownership, leasing, or management of all residential properties that
140.19 is used or could be used for providing home care services;

140.20 (12) documentation that the agency will use the following percentages of revenue
140.21 generated from the medical assistance rate paid for personal care assistance services for
140.22 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
140.23 care assistance choice option and 72.5 percent of revenue from other personal care assistance
140.24 providers. The revenue generated by the qualified professional and the reasonable costs
140.25 associated with the qualified professional shall not be used in making this calculation; and

140.26 (13) effective May 15, 2010, documentation that the agency does not burden recipients'
140.27 free exercise of their right to choose service providers by requiring personal care assistants
140.28 to sign an agreement not to work with any particular personal care assistance recipient or
140.29 for another personal care assistance provider agency after leaving the agency and that the
140.30 agency is not taking action on any such agreements or requirements regardless of the date
140.31 signed.

140.32 (b) Personal care assistance provider agencies shall provide the information specified
140.33 in paragraph (a) to the commissioner at the time the personal care assistance provider agency

141.1 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
141.2 the information specified in paragraph (a) from all personal care assistance providers
141.3 beginning July 1, 2009.

141.4 (c) All personal care assistance provider agencies shall require all employees in
141.5 management and supervisory positions and owners of the agency who are active in the
141.6 day-to-day management and operations of the agency to complete mandatory training as
141.7 determined by the commissioner before submitting an application for enrollment of the
141.8 agency as a provider. All personal care assistance provider agencies shall also require
141.9 qualified professionals to complete the training required by subdivision 13 before submitting
141.10 an application for enrollment of the agency as a provider. Employees in management and
141.11 supervisory positions and owners who are active in the day-to-day operations of an agency
141.12 who have completed the required training as an employee with a personal care assistance
141.13 provider agency do not need to repeat the required training if they are hired by another
141.14 agency, if they have completed the training within the past three years. By September 1,
141.15 2010, the required training must be available with meaningful access according to title VI
141.16 of the Civil Rights Act and federal regulations adopted under that law or any guidance from
141.17 the United States Health and Human Services Department. The required training must be
141.18 available online or by electronic remote connection. The required training must provide for
141.19 competency testing. Personal care assistance provider agency billing staff shall complete
141.20 training about personal care assistance program financial management. This training is
141.21 effective July 1, 2009. Any personal care assistance provider agency enrolled before that
141.22 date shall, if it has not already, complete the provider training within 18 months of July 1,
141.23 2009. Any new owners or employees in management and supervisory positions involved
141.24 in the day-to-day operations are required to complete mandatory training as a requisite of
141.25 working for the agency. Personal care assistance provider agencies certified for participation
141.26 in Medicare as home health agencies are exempt from the training required in this
141.27 subdivision. When available, Medicare-certified home health agency owners, supervisors,
141.28 or managers must successfully complete the competency test.

141.29 (d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability
141.30 insurance required by this subdivision must be maintained continuously and purchased new
141.31 annually. After initial enrollment, a provider must submit proof of bonds and required
141.32 coverages at any time at the request of the commissioner. Services provided while there are
141.33 lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions,
141.34 including termination. The commissioner shall send instructions and a due date to submit
141.35 the requested information to the personal care assistance provider agency.

142.1 Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is
142.2 amended to read:

142.3 Subd. 9. **Provider qualifications and duties.** A provider is eligible for reimbursement
142.4 under this section only if the provider:

142.5 (1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk
142.6 assessment under subdivision 10;

142.7 (2) is enrolled as a medical assistance Minnesota health care program provider and meets
142.8 all applicable provider standards and requirements;

142.9 (3) demonstrates compliance with federal and state laws and policies for housing
142.10 stabilization services as determined by the commissioner;

142.11 (4) complies with background study requirements under chapter 245C and maintains
142.12 documentation of background study requests and results;

142.13 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
142.14 determined by the commissioner, proof of surety bond coverage for each business location
142.15 providing services. Upon new enrollment, or if the provider's medical assistance revenue
142.16 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
142.17 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
142.18 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
142.19 must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually,
142.20 and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action
142.21 to obtain monetary recovery or sanctions from a surety bond must occur within six years
142.22 from the date the debt is affirmed by a final agency decision. An agency decision is final
142.23 when the right to appeal the debt has been exhausted or the time to appeal has expired under
142.24 section 256B.064;

142.25 (6) ensures all controlling individuals and employees of the agency complete annual
142.26 vulnerable adult training;

142.27 (7) completes compliance training as required under subdivision 11; and

142.28 (8) complies with the habitability inspection requirements in subdivision 13.

142.29 Sec. 29. Minnesota Statutes 2024, section 256B.27, subdivision 3, is amended to read:

142.30 Subd. 3. **Access to medical records.** The commissioner of human services, with the
142.31 written consent of the recipient, on file with the local welfare agency, shall be allowed
142.32 access in the manner and within the time prescribed by the commissioner to all personal

143.1 medical records of medical assistance recipients solely for the purposes of investigating
143.2 whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a
143.3 cost report or a rate application which is duplicative, erroneous, or false in whole or in part,
143.4 or which results in the vendor obtaining greater compensation than the vendor is legally
143.5 entitled to; or (b) the medical care was medically necessary. ~~When the commissioner is~~
143.6 ~~investigating a possible overpayment of Medicaid funds,~~ The commissioner may conduct
143.7 on-site inspections of any and all vendors and service locations or may request records from
143.8 a vendor to verify that information submitted to the commissioner is accurate, determine
143.9 compliance with service delivery and billing requirements, and determine compliance with
143.10 any other applicable laws or rules. The commissioner must be given immediate access
143.11 without prior notice to the vendor's office during regular business hours and to documentation
143.12 and records related to services provided and submission of claims for services provided.
143.13 The department shall document in writing the need for immediate access to records related
143.14 to a specific investigation. Denying the commissioner access to records is cause for the
143.15 vendor's immediate suspension of payment or termination according to section 256B.064.
143.16 The determination of provision of services not medically necessary shall be made by the
143.17 commissioner. Notwithstanding any other law to the contrary, a vendor of medical care
143.18 shall not be subject to any civil or criminal liability for providing access to medical records
143.19 to the commissioner of human services pursuant to this section.

143.20 Sec. 30. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 12, is amended
143.21 to read:

143.22 Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS
143.23 agency-providers must provide, at the time of enrollment, reenrollment, and revalidation
143.24 as a CFSS agency-provider in a format determined by the commissioner, information and
143.25 documentation that includes but is not limited to the following:

143.26 (1) the CFSS agency-provider's current contact information including address, telephone
143.27 number, and email address;

143.28 (2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's
143.29 Medicaid revenue in the previous calendar year is less than or equal to \$300,000, the
143.30 agency-provider must purchase a surety bond of \$50,000. If the agency-provider's Medicaid
143.31 revenue in the previous calendar year is greater than \$300,000, the agency-provider must
143.32 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the
143.33 commissioner, must be ~~renewed~~ purchased new annually, and must allow for recovery of
143.34 costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or

144.1 sanctions from a surety bond must occur within six years from the date the debt is affirmed
144.2 by a final agency decision. An agency decision is final when the right to appeal the debt
144.3 has been exhausted or the time to appeal has expired under section 256B.064;

144.4 (3) proof of fidelity bond coverage in the amount of \$20,000 per provider location;

144.5 (4) proof of workers' compensation insurance coverage;

144.6 (5) proof of liability insurance;

144.7 (6) a copy of the CFSS agency-provider's organizational chart identifying the names
144.8 and roles of all owners, managing employees, staff, board of directors, and additional
144.9 documentation reporting any affiliations of the directors and owners to other service
144.10 providers;

144.11 (7) proof that the CFSS agency-provider has written policies and procedures including:
144.12 hiring of employees; training requirements; service delivery; and employee and consumer
144.13 safety, including the process for notification and resolution of participant grievances, incident
144.14 response, identification and prevention of communicable diseases, and employee misconduct;

144.15 (8) proof that the CFSS agency-provider has all of the following forms and documents:

144.16 (i) a copy of the CFSS agency-provider's time sheet; and

144.17 (ii) a copy of the participant's individual CFSS service delivery plan;

144.18 (9) a list of all training and classes that the CFSS agency-provider requires of its staff
144.19 providing CFSS services;

144.20 (10) documentation that the CFSS agency-provider and staff have successfully completed
144.21 all the training required by this section;

144.22 (11) documentation of the agency-provider's marketing practices;

144.23 (12) disclosure of ownership, leasing, or management of all residential properties that
144.24 are used or could be used for providing home care services;

144.25 (13) documentation that the agency-provider will use at least the following percentages
144.26 of revenue generated from the medical assistance rate paid for CFSS services for CFSS
144.27 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except
144.28 100 percent of the revenue generated by a medical assistance rate increase due to a collective
144.29 bargaining agreement under section 179A.54 must be used for support worker wages and
144.30 benefits. The revenue generated by the worker training and development services and the
144.31 reasonable costs associated with the worker training and development services shall not be
144.32 used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if they are hired by another agency and they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

(d) Agency-providers shall submit all required documentation in this section within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Sec. 31. Minnesota Statutes 2025 Supplement, 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) be under contract with the department and enrolled as a Minnesota health care program provider;

(3) 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~~ purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) 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) be knowledgeable about self-directed principles and the application of the person-centered planning process;

(11) have general knowledge of the FMS provider duties and the vendor fiscal/employer agent model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

(12) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day management and operations of the agency, complete training as specified in the contract with the department.

Sec. 32. Minnesota Statutes 2025 Supplement, section 260E.03, subdivision 6, is amended to read:

Subd. 6. **Facility.** "Facility" means:

147.1 (1) a licensed or unlicensed day care facility, certified license-exempt child care center,
147.2 residential facility, agency, psychiatric residential treatment facility, hospital, sanitarium,
147.3 or other facility or institution required to be licensed under sections 144.50 to 144.58,
147.4 241.021, or 245A.01 to 245A.16, or chapter 142B, 142C, 144H, or 245D;

147.5 (2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E;
147.6 or

147.7 (3) a nonlicensed personal care provider organization as defined in section 256B.0625,
147.8 subdivision 19a.

147.9 Sec. 33. Minnesota Statutes 2025 Supplement, section 260E.11, subdivision 1, is amended
147.10 to read:

147.11 Subdivision 1. **Reports of maltreatment in facility.** A person mandated to report child
147.12 maltreatment occurring within a licensed facility ~~shall~~ must report the information to the
147.13 agency responsible for licensing or certifying the facility under sections 144.50 to 144.58,
147.14 241.021, and 245A.01 to 245A.16 or chapter 142B, 142C, 144H, or 245D or to a nonlicensed
147.15 personal care provider organization as defined in section 256B.0625, subdivision 19a. A
147.16 person mandated to report child maltreatment occurring within a federally certified
147.17 psychiatric residential treatment facility must report the information to the Department of
147.18 Health.

147.19 Sec. 34. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended
147.20 to read:

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

147.27 (b) The Department of Human Services is the agency responsible for screening and
147.28 investigating allegations of maltreatment in juvenile correctional facilities listed under
147.29 section 241.021 located in the local welfare agency's county and in facilities licensed or
147.30 certified under chapters 245A and 245D, except federally certified psychiatric residential
147.31 treatment facilities.

148.1 (c) The Department of Health is the agency responsible for screening and investigating
148.2 allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43
148.3 to 144A.482 ~~or~~, chapter 144H, or federally certified as a psychiatric residential treatment
148.4 facility.

148.5 (d) The Department of Education is the agency responsible for screening and investigating
148.6 allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11,
148.7 and 13, and chapter 124E. The Department of Education's responsibility to screen and
148.8 investigate includes allegations of maltreatment involving students 18 through 21 years of
148.9 age, including students receiving special education services, up to and including graduation
148.10 and the issuance of a secondary or high school diploma.

148.11 (e) The Department of Human Services is the agency responsible for screening and
148.12 investigating allegations of maltreatment of minors in an EIDBI agency operating under
148.13 sections 245A.142 and 256B.0949.

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

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

148.19 Sec. 35. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended
148.20 to read:

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

148.23 (a) The Department of Health is the lead investigative agency for facilities or services
148.24 licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding
148.25 care homes, hospice providers, residential facilities that are also federally certified as
148.26 intermediate care facilities that serve people with developmental disabilities, federally
148.27 certified psychiatric residential treatment facilities, or any other facility or service not listed
148.28 in this subdivision that is licensed or required to be licensed by the Department of Health
148.29 for the care of vulnerable adults. "Home care provider" has the meaning provided in section
148.30 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable
148.31 adult's home.

148.32 (b) The Department of Human Services is the lead investigative agency for facilities or
148.33 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, except federally certified psychiatric residential treatment facilities. 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.

Sec. 36. **NEW BACKGROUND STUDIES FOR INDIVIDUALS NOT IN NETSTUDY 2.0.**

By March 1, 2027, the commissioner of human services and counties must conduct new background studies for all individuals specified under Minnesota Statutes, section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), and affiliated with a child foster family setting license holder, adult foster care or family adult day services and with a family child care license holder, or a legal nonlicensed child care provider authorized under Minnesota Statutes, chapter 142E. The commissioner and counties must follow the requirements in Minnesota Statutes, section 245C.04, subdivision 1, paragraphs (e) and (f), when conducting the background studies under this section. The new background studies must be submitted through NETStudy 2.0.

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

Sec. 37. **REPEALER.**

(a) Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3a, is repealed.

(b) Minnesota Rules, part 9505.2165, subpart 4, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective October 1, 2026.

150.1 **ARTICLE 5**

150.2 **BACKGROUND STUDIES**

150.3 Section 1. Minnesota Statutes 2025 Supplement, section 245C.02, subdivision 15a, is
150.4 amended to read:

150.5 Subd. 15a. **Reasonable cause to require a national criminal history record check.** (a)
150.6 "Reasonable cause to require a national criminal history record check" means information
150.7 or circumstances exist that provide the commissioner with articulable suspicion that further
150.8 pertinent information may exist concerning a background study subject that merits conducting
150.9 a national criminal history record check on that subject. The commissioner has reasonable
150.10 cause to require a national criminal history record check when:

150.11 (1) information from the Bureau of Criminal Apprehension indicates that the subject is
150.12 a multistate offender;

150.13 (2) information from the Bureau of Criminal Apprehension indicates that multistate
150.14 offender status is undetermined;

150.15 (3) the commissioner has received a report from the subject or a third party indicating
150.16 that the subject has a criminal history in a jurisdiction other than Minnesota; or

150.17 (4) information from the Bureau of Criminal Apprehension for a state-based name and
150.18 date of birth background study in which the subject is a minor that indicates that the subject
150.19 has a criminal history.

150.20 (b) In addition to the circumstances described in paragraph (a), the commissioner has
150.21 reasonable cause to require a national criminal history record check if the subject is not
150.22 currently residing in Minnesota or resided in a jurisdiction other than Minnesota during the
150.23 previous five years.

150.24 (c) Reasonable cause to require a national criminal history check does not apply to family
150.25 child foster care ~~or~~ adoption, family adult day services, or adult foster care studies.

150.26 **EFFECTIVE DATE.** This section is effective January 25, 2028.

150.27 Sec. 2. Minnesota Statutes 2024, section 245C.03, subdivision 3a, is amended to read:

150.28 Subd. 3a. **Personal care assistance provider agency; background studies.** Personal
150.29 care assistance provider agencies enrolled to provide personal care assistance services under
150.30 the medical assistance program must meet the following requirements:

(1) owners who have a five percent interest or more, board members, and all managing employees are subject to a background study as provided in this chapter. This requirement applies to currently enrolled personal care assistance provider agencies and agencies seeking enrollment as a personal care assistance provider agency. "Managing employee" has the same meaning as in Code of Federal Regulations, title 42, section 455.101. An organization is barred from enrollment if:

(i) the organization has not initiated background studies of owners and managing employees; or

(ii) the organization has initiated background studies of owners and managing employees and the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set aside of the disqualification under section 245C.22; and

(2) a background study must be initiated and completed for all employee and volunteer qualified professionals.

EFFECTIVE DATE. This section is effective September 15, 2026.

Sec. 3. Minnesota Statutes 2024, section 245C.03, subdivision 9, is amended to read:

Subd. 9. **Community first services and supports and financial management services organizations.** Individuals affiliated with Community First Services and Supports (CFSS) agency-providers and Financial Management Services (FMS) providers enrolled to provide CFSS services under the medical assistance program must meet the following requirements:

(1) owners who have a five percent interest or more, board members, and all managing employees are subject to a background study under this chapter. This requirement applies to currently enrolled providers and agencies seeking enrollment. "Managing employee" has the meaning given in Code of Federal Regulations, title 42, section 455.101. An organization is barred from enrollment if:

(i) the organization has not initiated background studies of owners and managing employees; or

(ii) the organization has initiated background studies of owners and managing employees and the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14 and the owner or managing employee has not received a set aside of the disqualification under section 245C.22;

152.1 (2) a background study must be initiated and completed for all staff employees or
152.2 volunteers who will have direct contact with the participant to provide worker training and
152.3 development; and

152.4 (3) a background study must be initiated and completed for all employee and volunteer
152.5 support workers.

152.6 **EFFECTIVE DATE.** This section is effective September 15, 2026.

152.7 Sec. 4. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to
152.8 read:

152.9 **Subd. 17. Providers of adult rehabilitative mental health services.** The commissioner
152.10 must conduct background studies on any individual who is an owner with an ownership
152.11 stake of at least five percent in an adult rehabilitative mental health services provider, an
152.12 operator of an adult rehabilitative mental health services provider, or an employee or
152.13 volunteer who has direct contact with people receiving adult rehabilitative mental health
152.14 services under section 256B.0623. For purposes of this subdivision, operator includes board
152.15 members or other individuals who oversee the billing, management, or policies of the
152.16 services provided.

152.17 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,
152.18 but no sooner than October 13, 2026.

152.19 Sec. 5. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to
152.20 read:

152.21 **Subd. 18. Providers of peer recovery support services.** The commissioner shall conduct
152.22 background studies on any individual who is an owner with an ownership stake of at least
152.23 five percent in a peer recovery support services provider or an operator of a peer recovery
152.24 support services provider under section 254B.052. For the purposes of this subdivision,
152.25 "operator" includes board members or other individuals who oversee the billing, management,
152.26 or policies of the services provided.

152.27 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,
152.28 but no sooner than December 15, 2026.

153.1 Sec. 6. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to
153.2 read:

153.3 Subd. 19. **Providers of adult assertive community treatment services.** The
153.4 commissioner must conduct background studies on any individual who is an owner with
153.5 an ownership stake of at least five percent in an adult assertive community treatment services
153.6 provider, an operator of an adult assertive community treatment services provider, or an
153.7 employee or volunteer who has direct contact with people receiving adult assertive
153.8 community treatment services under section 256B.0622. For purposes of this subdivision,
153.9 "operator" includes board members or other individuals who oversee the billing, management,
153.10 or policies of the services provided.

153.11 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,
153.12 but no sooner than February 16, 2027.

153.13 Sec. 7. Minnesota Statutes 2025 Supplement, section 245C.05, subdivision 5, is amended
153.14 to read:

153.15 Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (c), for
153.16 background studies conducted by the commissioner for current or prospective child foster
153.17 or adoptive parents, and for any adult working in a children's residential facility, the subject
153.18 of the background study shall provide the commissioner with a set of classifiable fingerprints
153.19 obtained from an authorized agency for a national criminal history record check.

153.20 (b) Notwithstanding paragraph (c), for background studies conducted by the commissioner
153.21 for Head Start programs, the subject of the background study shall provide the commissioner
153.22 with a set of classifiable fingerprints obtained from an authorized agency for a national
153.23 criminal history record check.

153.24 (c) For background studies initiated on or after the implementation of NETStudy 2.0,
153.25 except as provided under subdivision 5a, every subject of a background study must provide
153.26 the commissioner with a set of the background study subject's classifiable fingerprints and
153.27 photograph. The photograph and fingerprints must be recorded at the same time by the
153.28 authorized fingerprint collection vendor or vendors and sent to the commissioner through
153.29 the commissioner's secure data system described in section 245C.32, subdivision 1a,
153.30 paragraph (b).

153.31 (d) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal
153.32 Apprehension and, when specifically required by law, submitted to the Federal Bureau of
153.33 Investigation for a national criminal history record check.

(e) The fingerprints must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints.

(f) The authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the name and date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(g) For any background study conducted under this chapter, except for family child foster care ~~or~~, adoption, family adult day services, or adult foster care studies, the subject shall provide the commissioner with a set of classifiable fingerprints when the commissioner has reasonable cause to require a national criminal history record check as defined in section 245C.02, subdivision 15a.

EFFECTIVE DATE. This section is effective January 25, 2028.

Sec. 8. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended to read:

Subd. 2. **Activities pending completion of background study.** The subject of a background study may not perform any activity requiring a background study under paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

(a) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245C.17 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual affiliated with a Title IV-E eligible children's residential facility or foster residence setting, the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

155.1 (2) a notice that a disqualification has been set aside under section 245C.23; or

155.2 (3) a notice that a variance has been granted related to the individual under section
155.3 245C.30.

155.4 (b) For a background study affiliated with a licensed child care center or certified
155.5 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),
155.6 must not be issued until the commissioner receives a qualifying result for the individual for
155.7 the fingerprint-based national criminal history record check or the fingerprint-based criminal
155.8 history information from the Bureau of Criminal Apprehension. The notice must require
155.9 the individual to be under continuous direct supervision prior to completion of the remainder
155.10 of the background study except as permitted in subdivision 3.

155.11 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

155.12 (1) being issued a license;

155.13 (2) living in the household where the licensed program will be provided;

155.14 (3) providing direct contact services to persons served by a program unless the subject
155.15 is under continuous direct supervision;

155.16 (4) having access to persons receiving services if the background study was completed
155.17 under section 144.057, subdivision 1, or 245C.03, ~~subdivision 1, paragraph (a), clause (2),~~
155.18 ~~(5), or (6),~~ unless the subject is under continuous direct supervision;

155.19 (5) for licensed child care centers and certified license-exempt child care centers,
155.20 providing direct contact services to persons served by the program;

155.21 (6) for children's residential facilities or foster residence settings, working in the facility
155.22 or setting; or

155.23 (7) for background studies affiliated with a personal care provider organization, ~~except~~
155.24 ~~as provided in section 245C.03, subdivision 3b, early intensive developmental and behavioral~~
155.25 intervention provider, housing support or supplementary services provider, special
155.26 transportation services provider, or community first services and supports provider before
155.27 ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider~~
155.28 ~~agency entity~~ must initiate a background study of the personal care assistant individual
155.29 under this chapter and the personal care assistance provider agency entity must have received
155.30 a notice from the commissioner that the personal care assistant individual is:

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

(ii) disqualified, but the ~~personal care assistant~~ individual has received a set aside of the disqualification under section 245C.22; ~~or,~~

~~(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:~~

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

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

EFFECTIVE DATE. This section is effective September 15, 2026.

Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended to read:

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

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

(1) the recency of the disqualifying characteristic;

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

(3) the number of disqualifying characteristics;

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

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

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

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

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

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

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

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

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1, or to a background study for an individual providing early intensive developmental and behavioral intervention services under section 256B.0949~~ 245C.13, subdivision 2, paragraph (c), clause (7).

(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 September 15, 2026.

ARTICLE 6

BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision to read:

Subd. 1a. **Direct payment.** For purposes of this section, "direct payment" means a funding mechanism used by the commissioner to distribute state appropriations to a county or Tribe for the purpose of carrying out duties, services, or activities authorized under this section. A direct payment is not a grant under section 16B.97 and is not subject to statewide grant-making policies and laws, including but not limited to sections 16A.15 and 16C.05, except as specifically required by the commissioner. A direct payment must be used for the purposes and allowable activities established by the commissioner and is subject to financial oversight, reporting, and monitoring requirements under subdivision 11.

Sec. 2. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision to read:

Subd. 3a. **Authority and rulemaking.** (a) The commissioner may distribute money under this section through direct payments to counties or Tribes when the commissioner determines that a direct payment is the most effective and efficient method to support the delivery of adult mental health services, Tribal government activities, or county responsibilities under this section. The commissioner shall establish eligibility criteria, allowable uses, documentation standards, and reporting requirements for recipients of direct payments. The commissioner is authorized to engage in rulemaking to fulfill the requirements of this subdivision.

(b) By January 1, 2027, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy that includes, at a minimum, the commissioner's plan for determining direct payment eligibility criteria, allowable uses of direct payments, documentation standards, and reporting requirements for recipients of direct payments.

Sec. 3. Minnesota Statutes 2025 Supplement, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Programs and eligible services and programs.** (a) The following three distinct ~~grant~~ programs ~~are funded~~ may receive direct payments under this section:

(1) mental health crisis services;

- 159.1 (2) housing with supports for adults with serious mental illness; and
- 159.2 (3) projects for assistance in transitioning from homelessness (PATH program).
- 159.3 (b) ~~In addition,~~ The following services are eligible for ~~grant funds~~ funding as direct
- 159.4 payments under this section as the payor of last resort:
- 159.5 (1) community education and prevention;
- 159.6 (2) client outreach;
- 159.7 (3) early identification and intervention;
- 159.8 (4) adult outpatient diagnostic assessment and psychological testing;
- 159.9 (5) peer support services;
- 159.10 (6) community support program services (CSP);
- 159.11 (7) adult residential crisis stabilization;
- 159.12 (8) supported employment;
- 159.13 (9) assertive community treatment (ACT);
- 159.14 (10) housing subsidies;
- 159.15 (11) basic living, social skills, and community intervention;
- 159.16 (12) emergency response services;
- 159.17 (13) adult outpatient psychotherapy;
- 159.18 (14) adult outpatient medication management;
- 159.19 (15) adult mobile crisis services, including the purchase and renovation of vehicles by
- 159.20 mobile crisis teams in order to provide protected transport under section 256B.0625,
- 159.21 subdivision 17, paragraph (l), clause (6);
- 159.22 (16) adult day treatment;
- 159.23 (17) partial hospitalization;
- 159.24 (18) adult residential treatment;
- 159.25 (19) adult mental health targeted case management; and
- 159.26 (20) transportation.
- 159.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2024, section 245.4661, subdivision 10, is amended to read:

Subd. 10. **Commissioner duty to report on use of grant funds biennially.** (a) By November 1, 2016, and biennially thereafter, the commissioner ~~of human services~~ shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to adult mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

(b) This subdivision expires January 1, 2032.

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

Sec. 5. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision to read:

Subd. 12. **Oversight of direct payments.** (a) The commissioner shall develop and maintain monitoring, financial review, and accountability procedures for all direct payments issued under this section.

(b) Recipients of direct payments must comply with all documentation, reporting, and expenditure requirements established by the commissioner.

(c) The commissioner may require corrective action, suspend payments, or recover money if a recipient fails to comply with requirements established under this subdivision.

(d) The commissioner shall develop a direct payment acknowledgment process to ensure that recipients understand the terms, conditions, and oversight requirements associated with direct payments.

(e) The commissioner is authorized to engage in rulemaking to fulfill the requirements of this subdivision.

(f) By January 1, 2027, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy that, at a minimum, describes the commissioner's development of the monitoring, financial review, and accountability procedures as required under this section.

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

Sec. 6. Minnesota Statutes 2024, section 254A.03, subdivision 2, is amended to read:

Subd. 2. **American Indian programs.** There is hereby created a section of American Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human Services, to be headed by a special assistant for American Indian programs on substance misuse and substance use disorder and two assistants to that position. The section shall be staffed with all personnel necessary to fully administer programming for substance misuse and substance use disorder services for American Indians in the state. The special assistant position shall be filled by a person with considerable practical experience in and understanding of substance misuse and substance use disorder in the American Indian community, who shall be responsible to the director of the Alcohol and Drug Abuse Section created in subdivision 1 and shall be in the unclassified service. The special assistant shall meet and consult with the American Indian Advisory Council as described in section 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report on the status of substance misuse and substance use disorder among American Indians in the state of Minnesota. The special assistant with the approval of the director shall:

(1) administer direct payments using funds appropriated for American Indian groups, organizations and reservations within the state for American Indian substance misuse and substance use disorder programs;

(2) establish policies and procedures for such American Indian programs with the assistance of the American Indian Advisory Board; and

(3) hire and supervise staff to assist in the administration of the American Indian program section within the Alcohol and Drug Abuse Section of the Department of Human Services.

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

Sec. 7. Minnesota Statutes 2025 Supplement, section 254B.02, subdivision 5, is amended to read:

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

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

162.2 Sec. 8. Minnesota Statutes 2025 Supplement, section 254B.0503, subdivision 1, is amended
162.3 to read:

162.4 Subdivision 1. **Eligible vendor requirements.** (a) Vendors of room and board are
162.5 eligible for behavioral health fund payment if the vendor:

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

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

162.9 (3) is not a jail or prison;

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

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

162.12 (6) is registered as a board and lodging or lodging establishment according to section
162.13 157.17;

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

162.15 (8) has staff who are at least 18 years of age and meet the requirements of section
162.16 245G.11, subdivision 1, paragraph (b);

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

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

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

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

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

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

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

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

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

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

163.9 (e) No new vendors for room and board services may be approved after June 30, 2025,
163.10 to receive payments from the behavioral health fund, under the provisions of section 254B.04,
163.11 subdivision 2a. Room and board vendors that were approved and operating prior to July 1,
163.12 2025, may continue to receive payments from the behavioral health fund for services provided
163.13 until ~~June 30, 2027~~ December 31, 2026. Room and board vendors providing services in
163.14 accordance with section 254B.04, subdivision 2a, will no longer be eligible to claim
163.15 reimbursement for room and board services provided on or after ~~July~~ January 1, 2027.

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

163.17 Sec. 9. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding
163.18 a subdivision to read:

163.19 Subd. 9. **Billing limits.** Treatment coordination must not exceed five hours per week
163.20 per recipient.

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

163.22 Sec. 10. Minnesota Statutes 2025 Supplement, section 254B.0509, subdivision 2, is
163.23 amended to read:

163.24 Subd. 2. **Annual adjustments.** Effective January 1, 2027, and annually thereafter, the
163.25 commissioner of human services must adjust the payment rates under ~~subdivision 1~~ section
163.26 254B.0505, subdivision 1, clauses (1) to (9), according to the change from the midpoint of
163.27 the previous rate year to the midpoint of the rate year for which the rate is being determined
163.28 using the Centers for Medicare and Medicaid Services Medicare Economic Index as
163.29 forecasted in the fourth quarter of the calendar year before the rate year. Notwithstanding
163.30 this subdivision, rates must not be adjusted lower than those established on January 1, 2026.

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

164.1 Sec. 11. Minnesota Statutes 2024, section 254B.17, is amended to read:

164.2 **254B.17 WITHDRAWAL MANAGEMENT START-UP AND**
164.3 **CAPACITY-BUILDING GRANTS.**

164.4 The commissioner must establish start-up and capacity-building grants for prospective
164.5 ~~or, new, or existing~~ substance use disorder treatment or withdrawal management programs
164.6 ~~licensed under chapter 245F~~ that will meet ASAM criteria for medically ~~monitored~~ managed
164.7 or clinically monitored levels of care by integrating withdrawal management services into
164.8 outpatient, intensive outpatient, or residential treatment services. Grants must be used to
164.9 measurably increase client capacity or expand available services and must align services
164.10 with ASAM criteria. Grants may be used to add medications for opioid use disorder to a
164.11 grantee's available services and for capacity-building expenses that are not reimbursable
164.12 under Minnesota health care programs, including but not limited to:

164.13 (1) costs associated with hiring staff or contracting with medical services providers;

164.14 (2) costs associated with staff retention;

164.15 (3) the purchase of office equipment and supplies;

164.16 (4) the purchase of software;

164.17 (5) costs associated with obtaining applicable and required licenses;

164.18 (6) business formation costs;

164.19 (7) costs associated with staff training; ~~and~~

164.20 (8) the purchase of medical equipment and supplies necessary to meet health and safety
164.21 requirements;

164.22 (9) costs associated with adding or improving physical space;

164.23 (10) start-up costs associated with adding new locations; and

164.24 (11) costs associated with becoming ASAM certified for medically managed levels of
164.25 care.

164.26 Sec. 12. Minnesota Statutes 2024, section 256B.04, subdivision 23, is amended to read:

164.27 Subd. 23. **Medical assistance costs for certain inmates.** (a) The commissioner shall
164.28 execute an interagency agreement with the commissioner of corrections to recover the state
164.29 cost attributable to medical assistance eligibility for inmates of public institutions admitted
164.30 to a medical institution on an inpatient basis. The annual amount to be transferred from the
164.31 Department of Corrections under the agreement must include all eligible state medical

165.1 assistance costs, including administrative costs incurred by the Department of Human
165.2 Services, attributable to inmates under state and county jurisdiction admitted to medical
165.3 institutions on an inpatient basis that are related to the implementation of section 256B.055,
165.4 subdivision 14, paragraph (c). This paragraph expires upon the effective date of paragraph
165.5 (b).

165.6 (b) Effective January 1, 2028, or upon federal approval, whichever is later, the
165.7 commissioner shall execute an interagency agreement with the commissioner of corrections
165.8 to recover the state cost attributable to medical assistance eligibility for inmates of public
165.9 institutions admitted to a medical institution on an inpatient basis. The annual amount to
165.10 be transferred from the Department of Corrections under the agreement must include all
165.11 eligible state medical assistance costs, including administrative costs incurred by the
165.12 Department of Human Services, attributable to inmates under state and county jurisdiction
165.13 admitted to medical institutions on an inpatient basis that are related to the implementation
165.14 of section 256B.0618, paragraph (b).

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

165.16 Sec. 13. **[256B.0618] COVERAGE FOR DETAINED INDIVIDUALS.**

165.17 (a) An inmate of a correctional facility who is conditionally released under section
165.18 241.26, 244.065, or 631.425 is eligible for medical assistance if the individual:

165.19 (1) does not require the security of a public detention facility and is housed:

165.20 (i) in a halfway house or community correction center; or

165.21 (ii) under house arrest and monitored by electronic surveillance in a residence approved
165.22 by the commissioner of corrections; and

165.23 (2) meets all other eligibility requirements of this chapter.

165.24 (b) An individual, regardless of age, who is considered an inmate of a public institution
165.25 as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the
165.26 eligibility requirements in section 256B.056 is not eligible for medical assistance, except
165.27 for covered medical assistance services received:

165.28 (1) while an inpatient in a medical institution as defined in Code of Federal Regulations,
165.29 title 42, section 435.1010;

165.30 (2) by an eligible juvenile in accordance with the Consolidated Appropriations Act,
165.31 2023, Public Law 117-328, part 5121; or

165.32 (3) by an eligible individual under section 256B.0761.

(c) Security logistics and costs related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 14. **[256B.0619] CARCERAL TARGETED CASE MANAGEMENT SERVICES.**

Subdivision 1. **Generally.** Effective January 1, 2028, or upon federal approval, whichever is later, medical assistance covers carceral targeted case management services in accordance with section 256B.0761 and United States Code, title 42, sections 1396a(a)(84); 1396d(a)(32); 1397bb(d); and 1397jj(b)(2) and (7).

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

(b) "Comprehensive care plan" means a person-centered plan that includes goals, tasks, and services identified through screening and assessments and agreed upon by all parties. A comprehensive care plan includes but is not limited to identifying resources and services necessary to meet the individual's physical, behavioral health, and health-related social needs prerelease and postrelease.

(c) "Consultation" means communication from a carceral targeted case manager to other providers working with the same justice-involved individual to (1) inform, inquire, and instruct providers on the individual's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, and (2) direct and coordinate clinical service components provided to the justice-involved individual. Service settings and components include but are not limited to education services, social services, probation, an individual's home, primary care, medication prescribers, disabilities services, and services from other mental health providers.

(d) "Targeted case management for justice-involved individuals" means the provision of both county targeted case management and public or private vendor service coordination services to bridge prerelease and postrelease medical assistance services that support the physical, behavioral, and health-related social needs of justice-involved individuals.

(e) "Targeted case management services" means services that assist medical assistance eligible persons with accessing needed medical, social, educational, and other services.

Subd. 3. **Eligibility.** The following individuals are eligible for carceral targeted case management services:

167.1 (1) individuals eligible for medical assistance who meet all eligibility requirements under
167.2 United States Code, title 42, section 1396a(nn);

167.3 (2) individuals eligible for medical assistance who meet eligibility requirements for the
167.4 Children's Health Insurance Program under United States Code, title 42, section 1397jj(b)(7);
167.5 or

167.6 (3) individuals eligible for medical assistance who are currently incarcerated at a section
167.7 1115 reentry demonstration pilot facility and meet the participation requirements in section
167.8 256B.0761, subdivision 2.

167.9 Subd. 4. **Carceral targeted case management services.** (a) For individuals eligible for
167.10 services under subdivision 3, clause (1) or (2), carceral targeted case management care
167.11 coordination is available for 30 days before release and up to 180 days postrelease. For
167.12 individuals eligible for services under subdivision 3, clause (3), carceral targeted case
167.13 management care coordination is available for up to 90 days before release and up to 180
167.14 days postrelease.

167.15 (b) Carceral targeted case management care coordination includes:

167.16 (1) comprehensive assessment and periodic reassessment addressing physical, behavioral,
167.17 and health-related social needs in accordance with section 256B.0761 and United States
167.18 Code, title 42, sections 1396a(nn) and 1397jj(b)(7);

167.19 (2) comprehensive care plans, including but not limited to:

167.20 (i) the desired goals of the individual;

167.21 (ii) the individual's preferences for services and supports;

167.22 (iii) formal and informal services and supports based on areas of assessment, such as
167.23 social health, mental health, residence, family, education and vocation, safety, legal,
167.24 self-determination, financial, and chemical health; and

167.25 (iv) housing arrangements postrelease;

167.26 (3) regular review and revision of the comprehensive care plan with the individual to
167.27 ensure needs are adequately met by referrals and supports;

167.28 (4) coordination of referrals, which must consist of efforts beyond providing a list of
167.29 resources, to bridge prerelease to postrelease medical assistance services, including but not
167.30 limited to referrals to community-based services identified as a need on the comprehensive
167.31 care plan;

168.1 (5) warm handoffs and postrelease follow-up through direct coordination between
168.2 providers, including timely communication, active engagement of the individual when
168.3 feasible, and facilitation of continuity of care upon release;

168.4 (6) monitoring and evaluation of services identified in the comprehensive care plan to
168.5 ensure personal outcomes are met and to ensure satisfaction with services and service
168.6 delivery;

168.7 (7) consultation with other professionals, including but not limited to community-based
168.8 mental health providers; and

168.9 (8) completion and maintenance of necessary documentation that supports and verifies
168.10 the activities in this section.

168.11 Subd. 5. **Carceral targeted case management provider standards.** Providers eligible
168.12 to receive medical assistance reimbursement under this section must enroll as a Minnesota
168.13 health care programs provider. To qualify as a provider of carceral targeted case management
168.14 services, a provider must:

168.15 (1) have a minimum of a bachelor's degree or a license in a health or human services
168.16 field, comparable training and two years of experience in human services, or credentials
168.17 from an American Indian Tribe under section 256B.02, subdivision 7;

168.18 (2) demonstrate the capacity and experience to provide targeted case management
168.19 activities for justice-involved individuals as defined in subdivision 2;

168.20 (3) be able to coordinate and connect community resources needed by the recipient;

168.21 (4) demonstrate administrative capacity and experience to serve the justice-involved
168.22 population for which the provider will provide services and to ensure quality of services
168.23 under state and federal requirements;

168.24 (5) have a financial management system that provides accurate documentation of services
168.25 and costs under state and federal requirements;

168.26 (6) demonstrate capacity to document and maintain individual case records under state
168.27 and federal requirements;

168.28 (7) demonstrate the capacity to coordinate with county administrative functions;

168.29 (8) be able to coordinate with health care providers to ensure access to necessary health
168.30 care services;

168.31 (9) have a procedure that:

169.1 (i) notifies the recipient of any conflict of interest if the targeted case management service
169.2 provider also provides the recipient's services and supports;

169.3 (ii) provides information on all potential conflicts of interest;

169.4 (iii) obtains the recipient's informed consent; and

169.5 (iv) provides the recipient with alternatives; and

169.6 (10) demonstrate the capacity to achieve the following performance outcomes: (i) access;
169.7 (ii) quality; and (iii) consumer satisfaction.

169.8 Subd. 6. **Medical assistance payment and rate setting.** (a) Carceral targeted case
169.9 management rates are equal to rates authorized by the commissioner for relocation targeted
169.10 case management under section 256B.0621, subdivision 10.

169.11 (b) The carceral targeted case management rate only includes eligible services delivered
169.12 to an eligible recipient by an eligible provider.

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

169.14 Sec. 15. Minnesota Statutes 2024, section 256B.0623, is amended by adding a subdivision
169.15 to read:

169.16 Subd. 15. **Billing limits.** Effective January 1, 2027, services under this section must not
169.17 exceed four hours per week per recipient, with a maximum of 18 hours per month. Prior
169.18 authorization is required for services exceeding 200 hours per year.

169.19 Sec. 16. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision
169.20 to read:

169.21 Subd. 78. **Carceral targeted case management.** Effective January 1, 2028, or upon
169.22 federal approval, whichever is later, medical assistance covers carceral targeted case
169.23 management services under section 256B.0619.

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

169.25 Sec. 17. Minnesota Statutes 2024, section 256B.0671, is amended by adding a subdivision
169.26 to read:

169.27 Subd. 14. **Billing limits.** Child and family psychoeducation services under this section
169.28 must not exceed two hours per day, three days per week per recipient.

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

Sec. 18. Minnesota Statutes 2024, section 256B.0761, subdivision 2, is amended to read:

Subd. 2. **Eligible individuals.** (a) Notwithstanding section 256B.055, subdivision 14, individuals are eligible to receive services under this demonstration if they are eligible under section 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the commissioner in collaboration with correctional facilities, local governments, and Tribal governments. This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2028, or upon federal approval, whichever is later, notwithstanding section 256B.0618, individuals are eligible to receive services under this demonstration if they are eligible under section 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the commissioner in collaboration with correctional facilities, local governments, and Tribal governments.

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

Sec. 19. Minnesota Statutes 2024, section 256B.0761, subdivision 3, is amended to read:

Subd. 3. **Eligible correctional facilities.** (a) The commissioner's waiver application is limited to:

(1) three state correctional facilities to be determined by the commissioner of corrections, one of which must be the Minnesota Correctional Facility-Shakopee;

~~(2) two facilities for delinquent children and youth licensed under section 241.021, subdivision 2, identified in coordination with the Minnesota Juvenile Detention Association and the Minnesota Sheriffs' Association;~~

~~(3)~~ (2) four correctional facilities for adults licensed under section 241.021, subdivision 1, identified in coordination with the Minnesota Sheriffs' Association and the Association of Minnesota Counties; and

~~(4)~~ (3) one correctional facility owned and managed by a Tribal government or a facility located outside of the seven-county metropolitan area that has an inmate census with a significant proportion of Tribal members or American Indians.

(b) Additional facilities may be added to the waiver contingent on legislative authorization and appropriations.

171.1 Sec. 20. Minnesota Statutes 2024, section 256B.0943, is amended by adding a subdivision
171.2 to read:

171.3 Subd. 15. **Billing limits.** (a) Skills training under this section must not exceed two hours
171.4 per day, three days per week per recipient. Prior authorization is required for services
171.5 exceeding 200 hours per year.

171.6 (b) Mental health behavioral aide services under this section must not exceed six hours
171.7 per day, three days per week per recipient. Prior authorization is required for services
171.8 exceeding 200 hours per year.

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

171.10 Sec. 21. Minnesota Statutes 2025 Supplement, section 256I.04, subdivision 2a, is amended
171.11 to read:

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

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

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

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

171.28 (4) ~~effective January 1, 2027~~ effective July 1, 2026, the establishment is licensed by the Department
171.29 of Health as a board and lodging establishment and is certified by the commissioner as a
171.30 recovery residence in accordance with section 254B.215, subdivision 3, that is subject to
171.31 the requirements of section 256I.04, subdivisions 2a to 2f. The Department of Human
171.32 Services must serve as the lead agency for agreements entered into under this clause.

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

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

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

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

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

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

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

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

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

172.18 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to
172.19 144A.483;

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

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

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

172.25 Sec. 22. Minnesota Statutes 2024, section 297E.02, subdivision 3, is amended to read:

172.26 Subd. 3. **Collection; disposition.** (a) Taxes imposed by this section are due and payable
172.27 to the commissioner when the gambling tax return is required to be filed. Distributors must
172.28 file their monthly sales figures with the commissioner on a form prescribed by the
172.29 commissioner. Returns covering the taxes imposed under this section must be filed with
172.30 the commissioner on or before the 20th day of the month following the close of the previous
172.31 calendar month. The commissioner shall prescribe the content, format, and manner of returns

173.1 or other documents pursuant to section 270C.30. The proceeds, along with the revenue
173.2 received from all license fees and other fees under sections 349.11 to 349.191, 349.211,
173.3 and 349.213, must be paid to the commissioner of management and budget for deposit in
173.4 the general fund.

173.5 (b) The sales tax imposed by chapter 297A on the sale of pull-tabs and tipboards by the
173.6 distributor is imposed on the retail sales price. The retail sale of pull-tabs or tipboards by
173.7 the organization is exempt from taxes imposed by chapter 297A and is exempt from all
173.8 local taxes and license fees except a fee authorized under section 349.16, subdivision 8.

173.9 (c) One-half of one percent of the revenue deposited in the general fund under paragraph
173.10 (a), is appropriated to the commissioner of human services for the compulsive gambling
173.11 treatment program established under section 245.98. One-half of one percent of the revenue
173.12 deposited in the general fund under paragraph (a), is appropriated to the commissioner of
173.13 human services for a grant to the state affiliate recognized by the National Council on
173.14 Problem Gambling to increase public awareness of problem gambling, education and training
173.15 for individuals and organizations providing effective treatment services to problem gamblers
173.16 and their families, and research relating to problem gambling. Money appropriated by this
173.17 paragraph must supplement and must not replace existing state funding for these programs.
173.18 The balance of amounts appropriated under this paragraph that are unencumbered and
173.19 unspent at the close of a fiscal year must be available in the next fiscal year for the same
173.20 purposes and must not cancel to the fund from which the amounts were appropriated.

173.21 (d) The commissioner of human services must provide to the state affiliate recognized
173.22 by the National Council on Problem Gambling a monthly statement of the amounts deposited
173.23 under paragraph (c). Beginning January 1, 2022, the commissioner of human services must
173.24 provide to the chairs and ranking minority members of the legislative committees with
173.25 jurisdiction over treatment for problem gambling and to the state affiliate recognized by the
173.26 National Council on Problem Gambling an annual reconciliation of the amounts deposited
173.27 under paragraph (c). The annual reconciliation under this paragraph must include the amount
173.28 allocated to the commissioner of human services for the compulsive gambling treatment
173.29 program established under section 245.98, and the amount allocated to the state affiliate
173.30 recognized by the National Council on Problem Gambling. The annual reconciliation must
173.31 also include any rollover amounts from the previous fiscal year and the utilization of those
173.32 amounts during the current reporting period.

174.1 Sec. 23. Laws 2025, First Special Session chapter 9, article 4, section 2, the effective date,
174.2 is amended to read:

174.3 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

174.5 Sec. 24. Laws 2025, First Special Session chapter 9, article 4, section 23, the effective
174.6 date, is amended to read:

174.7 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

174.9 Sec. 25. Laws 2025, First Special Session chapter 9, article 4, section 38, the effective
174.10 date, is amended to read:

174.11 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

174.13 Sec. 26. Laws 2025, First Special Session chapter 9, article 4, section 39, the effective
174.14 date, is amended to read:

174.15 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

174.17 Sec. 27. Laws 2025, First Special Session chapter 9, article 4, section 40, the effective
174.18 date, is amended to read:

174.19 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

174.21 Sec. 28. Laws 2025, First Special Session chapter 9, article 4, section 41, the effective
174.22 date, is amended to read:

174.23 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

174.25 Sec. 29. Laws 2025, First Special Session chapter 9, article 4, section 42, the effective
174.26 date, is amended to read:

174.27 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

175.2 Sec. 30. Laws 2025, First Special Session chapter 9, article 4, section 43, the effective
175.3 date, is amended to read:

175.4 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

175.6 Sec. 31. Laws 2025, First Special Session chapter 9, article 4, section 44, the effective
175.7 date, is amended to read:

175.8 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

175.10 Sec. 32. Laws 2025, First Special Session chapter 9, article 4, section 50, the effective
175.11 date, is amended to read:

175.12 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

175.14 Sec. 33. Laws 2025, First Special Session chapter 9, article 4, section 57, the effective
175.15 date, is amended to read:

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

175.21 Sec. 34. Laws 2026, chapter 95, article 5, section 23, subdivision 7, is amended to read:

175.22 Subd. 7. **Billing limits.** ~~Eligible vendors of Peer recovery support services must limit~~
175.23 ~~an individual client to not exceed~~ 14 hours per week for per recipient, of which no more
175.24 than two hours per day per recipient may be provided by telehealth. Peer recovery support
175.25 services ~~from an individual provider of peer recovery support services~~ must not exceed 520
175.26 hours annually per recipient.

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

176.1 Sec. 35. **DIRECTION TO COMMISSIONER; CARCERAL TARGETED CASE**
176.2 **MANAGEMENT SERVICES BILLING UNITS.**

176.3 The commissioner of human services must establish a new billing code for carceral
176.4 targeted case management services. The commissioner must identify reimbursement rates
176.5 for the newly defined codes, as required under Minnesota Statutes, section 256B.0619,
176.6 subdivision 6. The new billing codes must correspond to a 15-minute unit and must be
176.7 available for 180 days postrelease.

176.8 **EFFECTIVE DATE.** This section is effective January 1, 2028, or upon federal approval,
176.9 whichever is later.

176.10 Sec. 36. **REPEALER.**

176.11 Minnesota Statutes 2024, section 256B.055, subdivision 14, is repealed.

176.12 **EFFECTIVE DATE.** This section is effective January 1, 2028, or upon federal approval,
176.13 whichever is later.

176.14 **ARTICLE 7**

176.15 **UNIFORM SERVICE STANDARDS**

176.16 Section 1. Minnesota Statutes 2024, section 245.735, subdivision 6, is amended to read:

176.17 Subd. 6. **Section 223 of the Protecting Access to Medicare Act entities.** ~~(a) The~~
176.18 ~~commissioner must request federal approval to participate in the demonstration program~~
176.19 ~~established by section 223 of the Protecting Access to Medicare Act and, if approved, to~~
176.20 ~~continue to participate in the demonstration program as long as federal funding for the~~
176.21 ~~demonstration program remains available from the United States Department of Health and~~
176.22 ~~Human Services. To the extent practicable, the commissioner shall align the requirements~~
176.23 ~~of the demonstration program with the requirements under this section for CCBHCs receiving~~
176.24 ~~medical assistance reimbursement under the authority of the state's Medicaid state plan. A~~
176.25 ~~CCBHC may not apply to participate as a billing provider in both the CCBHC federal~~
176.26 ~~demonstration and the benefit for CCBHCs under the medical assistance program.~~

176.27 ~~(b) The commissioner must follow federal payment guidance, including payment of the~~
176.28 ~~CCBHC daily bundled rate for services rendered by CCBHCs to individuals who are dually~~
176.29 ~~eligible for Medicare and medical assistance when Medicare is the primary payer for the~~
176.30 ~~service. Services provided by a CCBHC operating under the authority of the state's Medicaid~~
176.31 ~~state plan will not receive the prospective payment system rate for services rendered by~~

177.1 ~~CCBHCs to individuals who are dually eligible for Medicare and medical assistance when~~
177.2 ~~Medicare is the primary payer for the service.~~

177.3 ~~(e) Payment for services rendered by CCBHCs to individuals who have commercial~~
177.4 ~~insurance as the primary payer and medical assistance as secondary payer is subject to the~~
177.5 ~~requirements under section 256B.37. Services provided by a CCBHC operating under the~~
177.6 ~~authority of the 223 demonstration or the state's Medicaid state plan will not receive the~~
177.7 ~~prospective payment system rate for services rendered by CCBHCs to individuals who have~~
177.8 ~~commercial insurance as the primary payer and medical assistance as the secondary payer.~~

177.9 Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended
177.10 to read:

177.11 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

177.12 (1) residential or nonresidential programs that are provided to a person by an individual
177.13 who is related;

177.14 (2) nonresidential programs that are provided by an unrelated individual to persons from
177.15 a single related family;

177.16 (3) residential or nonresidential programs that are provided to adults who do not misuse
177.17 substances or have a substance use disorder, a mental illness, a developmental disability, a
177.18 functional impairment, or a physical disability;

177.19 (4) sheltered workshops or work activity programs that are certified by the commissioner
177.20 of employment and economic development;

177.21 (5) programs operated by a public school for children 33 months or older;

177.22 (6) nonresidential programs primarily for children that provide care or supervision for
177.23 periods of less than three hours a day while the child's parent or legal guardian is in the
177.24 same building as the nonresidential program or present within another building that is
177.25 directly contiguous to the building in which the nonresidential program is located;

177.26 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
177.27 under section 245A.02;

177.28 (8) board and lodge facilities licensed by the commissioner of health that do not provide
177.29 children's residential services under Minnesota Rules, chapter 2960, mental health or
177.30 substance use disorder treatment;

177.31 (9) programs licensed by the commissioner of corrections;

- 178.1 (10) recreation programs for children or adults that are operated or approved by a park
178.2 and recreation board whose primary purpose is to provide social and recreational activities;
- 178.3 (11) noncertified boarding care homes unless they provide services for five or more
178.4 persons whose primary diagnosis is mental illness or a developmental disability;
- 178.5 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art
178.6 programs, and nonresidential programs for children provided for a cumulative total of less
178.7 than 30 days in any 12-month period;
- 178.8 (13) residential programs for persons with mental illness, that are located in hospitals;
- 178.9 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter
178.10 4630;
- 178.11 (15) mental health outpatient services for adults with mental illness or children with
178.12 mental illness, except, effective January 1, 2028, for programs licensed under section
178.13 245A.044;
- 178.14 (16) residential programs serving school-age children whose sole purpose is cultural or
178.15 educational exchange, until the commissioner adopts appropriate rules;
- 178.16 (17) community support services programs as defined in section 245.462, subdivision
178.17 6, and family community support services as defined in section 245.4871, subdivision 17;
- 178.18 (18) assisted living facilities licensed by the commissioner of health under chapter 144G;
- 178.19 (19) substance use disorder treatment activities of licensed professionals in private
178.20 practice as defined in section 245G.01, subdivision 17;
- 178.21 (20) consumer-directed community support service funded under the Medicaid waiver
178.22 for persons with developmental disabilities when the individual who provided the service
178.23 is:
- 178.24 (i) the same individual who is the direct payee of these specific waiver funds or paid by
178.25 a fiscal agent, fiscal intermediary, or employer of record; and
- 178.26 (ii) not otherwise under the control of a residential or nonresidential program that is
178.27 required to be licensed under this chapter when providing the service;
- 178.28 (21) a county that is an eligible vendor under section 254B.0501 to provide care
178.29 coordination and comprehensive assessment services;
- 178.30 (22) a recovery community organization that is an eligible vendor under section
178.31 254B.0501 to provide peer recovery support services; or

179.1 (23) programs licensed by the commissioner of children, youth, and families in chapter
179.2 142B.

179.3 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
179.4 building in which a nonresidential program is located if it shares a common wall with the
179.5 building in which the nonresidential program is located or is attached to that building by
179.6 skyway, tunnel, atrium, or common roof.

179.7 (c) Except for the home and community-based services identified in section 245D.03,
179.8 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
179.9 provided and funded according to an approved federal waiver plan where licensure is
179.10 specifically identified as not being a condition for the services and funding.

179.11 Sec. 3. **[245A.044] LICENSED NONRESIDENTIAL BEHAVIORAL HEALTH**
179.12 **SERVICES.**

179.13 **Subdivision 1. License required for certain nonresidential behavioral health**
179.14 **services.** (a) Beginning January 1, 2028, providers of nonresidential mental health and
179.15 **substance use disorder services must obtain a license under this chapter to provide:**

179.16 **(1) adult rehabilitative mental health services under section 245I.22;**

179.17 **(2) children's therapeutic services and supports in the community under section 245I.30**
179.18 **and children's day treatment under section 245I.31;**

179.19 **(3) crisis response services under section 245I.24; and**

179.20 **(4) certified community behavioral health clinic services under section 245I.17.**

179.21 (b) **As a condition of licensure, an applicant or license holder must demonstrate and**
179.22 **maintain verification of compliance with:**

179.23 **(1) licensing requirements under this chapter and chapter 245I; and**

179.24 **(2) applicable health care program requirements under Minnesota Rules, parts 9505.0170**
179.25 **to 9505.0475 and 9505.2160 to 9505.2245.**

179.26 **Subd. 2. Implementation.** (a) Beginning July 1, 2027, the commissioner must begin
179.27 **issuing licenses to providers listed in subdivision 1. The commissioner must transition**
179.28 **providers certified under section 245I.011 and listed in subdivision 1 into licensure with a**
179.29 **phased-in schedule determined by the commissioner. The commissioner must communicate**
179.30 **the implementation schedule to providers at least three months before the application is**
179.31 **made available.**

(b) Applicants for licensure must have an approved certification under section 245I.011 at least 90 days before the date of the licensure application.

(c) A provider's certification under section 245I.011, subdivision 5, paragraph (a), clauses (2) to (4), or 6, paragraph (b), expires when the commissioner issues a decision on the provider's license application.

(d) Upon licensure, a license holder must notify clients and staff of policies and procedures outlined in the application.

(e) Notwithstanding paragraphs (a) and (c), subdivision 1, and sections 245I.17, 245I.22, 245I.24, 245I.30, and 245I.31, a provider listed under subdivision 1, paragraph (a), clauses (1) to (4), and certified under section 245I.011 may continue operating past January 1, 2028, until the commissioner issues a licensing decision if the provider submitted an application before January 1, 2028.

(f) If a provider fails to submit an application for licensure within six months of the application being made available, the commissioner must disenroll the provider from reimbursement for the following services:

(1) adult rehabilitative mental health services under section 256B.0623;

(2) crisis response services under section 256B.0624;

(3) children's therapeutic services and supports under section 256B.0943; and

(4) certified community behavioral health clinics under section 256B.0625, subdivision 5m.

(g) The commissioner must disenroll a provider listed in paragraph (f) from medical assistance if:

(1) the provider's licensing application has been denied or the license has been suspended or revoked; and

(2) the provider appealed the application denial or the license suspension or revocation, and the commissioner issued a final order on the appeal affirming the action.

Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) Except as provided in paragraphs (c) ~~and~~, (d), and (f), for fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a \$2,100 application

181.1 fee with each new application required under this subdivision. The application fee shall not
 181.2 be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that
 181.3 expires on December 31. The commissioner shall not process an application until the
 181.4 application fee is paid.

181.5 (b) Except as provided in paragraph (c), an applicant shall apply for a license to provide
 181.6 services at a specific location.

181.7 (c) For a license to provide home and community-based services to persons with
 181.8 disabilities or age 65 and older under chapter 245D, an applicant shall submit an application
 181.9 to provide services statewide. For fees required under subdivision 1, an applicant for an
 181.10 initial license issued by the commissioner to provide home and community-based services
 181.11 under chapter 245D shall submit a \$4,200 application fee with each new application.

181.12 (d) For fees required under subdivision 1, an applicant for an initial license or certification
 181.13 issued by the commissioner for children's residential facility ~~or mental health clinic licensure~~
 181.14 ~~or certification~~ shall submit a \$500 application fee with each new application required under
 181.15 this subdivision.

181.16 (e) For fees required under subdivision 1, an applicant for an initial mental health clinic
 181.17 certification issued by the commissioner shall submit a \$2,100 application fee with each
 181.18 new application required under this subdivision.

181.19 (f) For fees required under subdivision 1, an applicant for an initial license issued by
 181.20 the commissioner to provide services at a certified community behavioral health clinic under
 181.21 section 245I.17 shall submit a \$4,200 application fee with each new application.

181.22 Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended
 181.23 to read:

181.24 Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed
 181.25 to provide one or more of the home and community-based services and supports identified
 181.26 under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual
 181.27 nonrefundable license fee based on revenues derived from the provision of services that
 181.28 would require licensure under chapter 245D during the calendar year immediately preceding
 181.29 the year in which the license fee is paid, according to the following schedule:

181.30 License Holder Annual Revenue	License Fee
181.31 less than or equal to \$10,000	\$250
181.32 greater than \$10,000 but less than or	
181.33 equal to \$25,000	\$375

182.1	greater than \$25,000 but less than or	
182.2	equal to \$50,000	\$500
182.3	greater than \$50,000 but less than or	
182.4	equal to \$100,000	\$625
182.5	greater than \$100,000 but less than or	
182.6	equal to \$150,000	\$750
182.7	greater than \$150,000 but less than or	
182.8	equal to \$200,000	\$1,000
182.9	greater than \$200,000 but less than or	
182.10	equal to \$250,000	\$1,250
182.11	greater than \$250,000 but less than or	
182.12	equal to \$300,000	\$1,500
182.13	greater than \$300,000 but less than or	
182.14	equal to \$350,000	\$1,750
182.15	greater than \$350,000 but less than or	
182.16	equal to \$400,000	\$2,000
182.17	greater than \$400,000 but less than or	
182.18	equal to \$450,000	\$2,250
182.19	greater than \$450,000 but less than or	
182.20	equal to \$500,000	\$2,500
182.21	greater than \$500,000 but less than or	
182.22	equal to \$600,000	\$2,850
182.23	greater than \$600,000 but less than or	
182.24	equal to \$700,000	\$3,200
182.25	greater than \$700,000 but less than or	
182.26	equal to \$800,000	\$3,600
182.27	greater than \$800,000 but less than or	
182.28	equal to \$900,000	\$3,900
182.29	greater than \$900,000 but less than or	
182.30	equal to \$1,000,000	\$4,250
182.31	greater than \$1,000,000 but less than or	
182.32	equal to \$1,250,000	\$4,550
182.33	greater than \$1,250,000 but less than or	
182.34	equal to \$1,500,000	\$4,900
182.35	greater than \$1,500,000 but less than or	
182.36	equal to \$1,750,000	\$5,200
182.37	greater than \$1,750,000 but less than or	
182.38	equal to \$2,000,000	\$5,500
182.39	greater than \$2,000,000 but less than or	
182.40	equal to \$2,500,000	\$5,900
182.41	greater than \$2,500,000 but less than or	
182.42	equal to \$3,000,000	\$6,200
182.43	greater than \$3,000,000 but less than or	
182.44	equal to \$3,500,000	\$6,500
182.45	greater than \$3,500,000 but less than or	
182.46	equal to \$4,000,000	\$7,200

183.1	greater than \$4,000,000 but less than or	
183.2	equal to \$4,500,000	\$7,800
183.3	greater than \$4,500,000 but less than or	
183.4	equal to \$5,000,000	\$9,000
183.5	greater than \$5,000,000 but less than or	
183.6	equal to \$7,500,000	\$10,000
183.7	greater than \$7,500,000 but less than or	
183.8	equal to \$10,000,000	\$14,000
183.9	greater than \$10,000,000 but less than or	
183.10	equal to \$12,500,000	\$18,000
183.11	greater than \$12,500,000 but less than or	
183.12	equal to \$15,000,000	\$25,000
183.13	greater than \$15,000,000 but less than or	
183.14	equal to \$17,500,000	\$28,000
183.15	greater than \$17,500,000 but less than	
183.16	\$20,000,000	\$32,000
183.17	greater than \$20,000,000 but less than	
183.18	\$25,000,000	\$36,000
183.19	greater than \$25,000,000 but less than	
183.20	\$30,000,000	\$45,000
183.21	greater than \$30,000,000 but less than	
183.22	\$35,000,000	\$55,000
183.23	greater than \$35,000,000	\$75,000

183.24

(2) If requested, the license holder shall provide the commissioner information to verify

183.25

the license holder's annual revenues or other information as needed, including copies of

183.26

documents submitted to the Department of Revenue.

183.27

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee,

183.28

and not provide annual revenue information to the commissioner.

183.29

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts

183.30

for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount

183.31

of double the fee the provider should have paid.

183.32

(b) A substance use disorder treatment program licensed under chapter 245G, to provide

183.33

substance use disorder treatment shall pay an annual nonrefundable license fee based on

183.34

the following schedule:

183.35	Licensed Capacity	License Fee
183.36	1 to 24 persons	\$2,600
183.37	25 to 49 persons	\$3,000
183.38	50 to 74 persons	\$5,000
183.39	75 to 99 persons	\$10,000

184.1 100 to 199 persons \$15,000

184.2 200 or more persons \$20,000

184.3 (c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to
 184.4 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay
 184.5 an annual nonrefundable license fee based on the following schedule:

184.6	Licensed Capacity	License Fee

184.7	1 to 24 persons	\$2,600

184.8	25 to 49 persons	\$3,000

184.9	50 or more persons	\$5,000

184.10 A detoxification program that also operates a withdrawal management program at the same
 184.11 location shall only pay one fee based upon the licensed capacity of the program with the
 184.12 higher overall capacity.

184.13 (d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to
 184.14 serve children shall pay an annual nonrefundable license fee based on the following schedule:

184.15	Licensed Capacity	License Fee

184.16	1 to 24 persons	\$1,000

184.17	25 to 49 persons	\$1,100

184.18	50 to 74 persons	\$1,200

184.19	75 to 99 persons	\$1,300

184.20	100 or more persons	\$1,400

184.21 (e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
 184.22 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual
 184.23 nonrefundable license fee based on the following schedule:

184.24	Licensed Capacity	License Fee

184.25	1 to 24 persons	\$2,600

184.26	25 to 49 persons	\$3,000

184.27	50 or more persons	\$20,000

184.28 (f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 184.29 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 184.30 based on the following schedule:

184.31	Licensed Capacity	License Fee

184.32	1 to 24 persons	\$450

184.33	25 to 49 persons	\$650

184.34	50 to 74 persons	\$850

185.1 75 to 99 persons \$1,050

185.2 100 or more persons \$1,250

185.3 (g) A program licensed as an adult day care center licensed under Minnesota Rules,
185.4 parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
185.5 following schedule:

185.6	Licensed Capacity	License Fee
185.7	1 to 24 persons	\$2,600
185.8	25 to 49 persons	\$3,000
185.9	50 to 74 persons	\$5,000
185.10	75 to 99 persons	\$10,000
185.11	100 to 199 persons	\$15,000
185.12	200 or more persons	\$20,000

185.13 (h) A program licensed to provide treatment services to persons with sexual psychopathic
185.14 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
185.15 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

185.16 (i) A mental health clinic certified under section 245I.20 shall pay an annual
185.17 nonrefundable certification fee of ~~\$1,550~~ \$3,000. If the mental health clinic provides services
185.18 at a primary location with satellite facilities, the satellite facilities shall be certified with the
185.19 primary location without an additional charge.

185.20 ~~(j) If a program subject to annual fees under paragraph (b) provides services at a primary~~
185.21 ~~location with satellite facilities, the satellite facilities must be licensed with the primary~~
185.22 ~~location and must be subject to an additional \$500 annual nonrefundable license fee per~~
185.23 ~~satellite facility.~~

185.24 (j) A program licensed to provide behavioral health treatment services licensed under
185.25 section 245I.22, 245I.24, 245I.30, or 245I.31 shall pay an annual nonrefundable license fee
185.26 of \$3,000 for each license.

185.27 (k) Certified community behavioral health clinics licensed under section 245I.17 shall
185.28 pay an annual nonrefundable license fee of \$7,800.

185.29 Sec. 6. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to
185.30 read:

185.31 Subd. 4a. **Fees for satellite locations.** (a) If a program subject to annual fees under
185.32 subdivision 4, paragraph (b), provides services at a primary location with satellite facilities,

186.1 the satellite facilities are licensed with the primary location and are subject to an additional
186.2 \$500 annual nonrefundable license fee per satellite facility.

186.3 (b) If a program subject to annual fees under subdivision 4, paragraph (j), provides
186.4 services at a primary location with satellite sites or facilities, the satellite locations must be
186.5 licensed with the primary location and are subject to an additional annual nonrefundable
186.6 fee according to the following schedule:

186.7 (1) one to five satellite locations: \$1,500;

186.8 (2) six to 19 satellite locations: \$3,500; or

186.9 (3) 20 or more satellite locations: \$5,000.

186.10 Sec. 7. Minnesota Statutes 2024, section 245A.65, subdivision 1a, is amended to read:

186.11 Subd. 1a. **Determination of vulnerable adult status.** (a) A license holder that provides
186.12 services to adults who are excluded from the definition of vulnerable adult under section
186.13 626.5572, subdivision 21, paragraph (a), clause (2), must determine whether the person is
186.14 a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4). This
186.15 determination must be made within 24 hours of:

186.16 (1) admission to the licensed program; and

186.17 (2) any incident that:

186.18 (i) was reported under section 626.557; or

186.19 (ii) would have been required to be reported under section 626.557, if one or more of
186.20 the adults involved in the incident had been vulnerable adults.

186.21 (b) Upon determining that a person receiving services is a vulnerable adult under section
186.22 626.5572, subdivision 21, paragraph (a), clause (4), all requirements relative to vulnerable
186.23 adults under this chapter and section 626.557 must be met by the license holder.

186.24 (c) Notwithstanding paragraph (a), clause (1), a license holder providing mobile crisis
186.25 services must make the required determination within 24 hours of first providing crisis
186.26 stabilization services to an adult under section 245I.24, subdivision 9.

186.27 Sec. 8. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

186.28 Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall
186.29 conduct a background study on:

186.30 (1) the person or persons applying for a license;

187.1 (2) an individual age 13 and over living in the household where the licensed program
187.2 will be provided who is not receiving licensed services from the program;

187.3 (3) current or prospective employees of the applicant or license holder who will have
187.4 direct contact with persons served by the facility, agency, or program;

187.5 (4) volunteers or student volunteers who will have direct contact with persons served
187.6 by the program to provide program services if the contact is not under the continuous, direct
187.7 supervision by an individual listed in clause (1) or (3);

187.8 (5) an individual age ten to 12 living in the household where the licensed services will
187.9 be provided when the commissioner has reasonable cause as defined in section 245C.02,
187.10 subdivision 15;

187.11 (6) an individual who, without providing direct contact services at a licensed program,
187.12 may have unsupervised access to children or vulnerable adults receiving services from a
187.13 program, when the commissioner has reasonable cause as defined in section 245C.02,
187.14 subdivision 15; and

187.15 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

187.16 (8) notwithstanding clause (3), for children's residential facilities and foster residence
187.17 settings, any adult working in the facility, whether or not the individual will have direct
187.18 contact with persons served by the facility.

187.19 (b) For child foster care when the license holder resides in the home where foster care
187.20 services are provided, a short-term substitute caregiver providing direct contact services for
187.21 a child for less than 72 hours of continuous care is not required to receive a background
187.22 study under this chapter.

187.23 (c) This subdivision applies to the following programs that must be licensed under
187.24 chapter 245A:

187.25 (1) adult foster care;

187.26 (2) children's residential facilities;

187.27 (3) licensed home and community-based services under chapter 245D;

187.28 (4) residential mental health programs for adults;

187.29 (5) substance use disorder treatment programs under chapter 245G;

187.30 (6) withdrawal management programs under chapter 245F;

187.31 (7) adult day care centers;

- 188.1 (8) family adult day services;
- 188.2 (9) detoxification programs;
- 188.3 (10) community residential settings;
- 188.4 (11) intensive residential treatment services and residential crisis stabilization under
- 188.5 chapter 245I; ~~and~~
- 188.6 (12) treatment programs for persons with sexual psychopathic personality or sexually
- 188.7 dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts
- 188.8 9515.3000 to 9515.3110-;
- 188.9 (13) adult rehabilitative mental health services under chapter 245I;
- 188.10 (14) certified community behavioral health clinic services under chapter 245I;
- 188.11 (15) children's therapeutic services and supports under chapter 245I; and
- 188.12 (16) crisis response services under chapter 245I.
- 188.13 Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended
- 188.14 to read:
- 188.15 Subd. 2. **Activities pending completion of background study.** The subject of a
- 188.16 background study may not perform any activity requiring a background study under
- 188.17 paragraph (c) until the commissioner has issued one of the notices under paragraph (a).
- 188.18 (a) Notices from the commissioner required prior to activity under paragraph (c) include:
- 188.19 (1) a notice of the study results under section 245C.17 stating that:
- 188.20 (i) the individual is not disqualified; or
- 188.21 (ii) more time is needed to complete the study but the individual is not required to be
- 188.22 removed from direct contact or access to people receiving services prior to completion of
- 188.23 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
- 188.24 that more time is needed to complete the study must also indicate whether the individual is
- 188.25 required to be under continuous direct supervision prior to completion of the background
- 188.26 study. When more time is necessary to complete a background study of an individual
- 188.27 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,
- 188.28 the individual may not work in the facility or setting regardless of whether or not the
- 188.29 individual is supervised;
- 188.30 (2) a notice that a disqualification has been set aside under section 245C.23; or

189.1 (3) a notice that a variance has been granted related to the individual under section
189.2 245C.30.

189.3 (b) For a background study affiliated with a licensed child care center or certified
189.4 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),
189.5 must not be issued until the commissioner receives a qualifying result for the individual for
189.6 the fingerprint-based national criminal history record check or the fingerprint-based criminal
189.7 history information from the Bureau of Criminal Apprehension. The notice must require
189.8 the individual to be under continuous direct supervision prior to completion of the remainder
189.9 of the background study except as permitted in subdivision 3.

189.10 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

189.11 (1) being issued a license;

189.12 (2) living in the household where the licensed program will be provided;

189.13 (3) providing direct contact services to persons served by a program unless the subject
189.14 is under continuous direct supervision;

189.15 (4) having access to persons receiving services if the background study was completed
189.16 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),
189.17 (5), or (6), unless the subject is under continuous direct supervision;

189.18 (5) for licensed child care centers and certified license-exempt child care centers,
189.19 providing direct contact services to persons served by the program;

189.20 (6) for children's residential facilities or foster residence settings, working in the facility
189.21 or setting;

189.22 (7) for background studies affiliated with a personal care provider organization, except
189.23 as provided in section 245C.03, subdivision 3b, or with an early intensive developmental
189.24 and behavioral intervention provider or adult rehabilitative mental health services provider,
189.25 ~~before a personal care assistant~~ an individual provides services, the ~~personal care assistance~~
189.26 ~~provider agency entity~~ must initiate a background study of the ~~personal care assistant~~
189.27 individual under this chapter and the ~~personal care assistance provider agency entity~~ must
189.28 have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

189.30 (ii) disqualified, but the personal care assistant has received a set aside of the
189.31 disqualification under section 245C.22; or

(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:

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

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

Sec. 10. Minnesota Statutes 2024, section 245G.03, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in section 626.557; chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under section ~~245.735~~ 245I.17, the license holder must comply with the requirements in section ~~245.735~~ 245I.17, subdivisions ~~4b to 4e~~ 12 and 13, as part of the licensing requirements under this chapter.

Sec. 11. Minnesota Statutes 2024, section 245I.011, subdivision 3, is amended to read:

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause ~~(12)~~ (15), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

~~(c) If a clinic is certified according to this chapter and is part of a certified community behavioral health clinic under section 245.735, the license holder must comply with the requirements in section 245.735, subdivisions 4b to 4e, as part of the licensing requirements under this chapter.~~

Sec. 12. Minnesota Statutes 2024, section 245I.011, subdivision 5, is amended to read:

Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or government entity certified under the following sections must comply with all of the responsibilities assigned to a license holder under this chapter except subdivision 1:

(1) an assertive community treatment provider under section 256B.0622, subdivision 3a;

~~(2) an adult rehabilitative mental health services provider under section 256B.0623;~~

~~(3) a mobile crisis team under section 256B.0624;~~

~~(4) a children's therapeutic services and supports provider under section 256B.0943;~~

~~(5)~~ (2) a children's intensive behavioral health services provider under section 256B.0946; and

~~(6)~~ (3) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947.

(b) An individual, organization, or government entity certified under the sections listed in paragraph (a), ~~clauses (1) to (6)~~, must obtain a criminal background study for each staff person and volunteer providing direct contact services to a client.

Sec. 13. Minnesota Statutes 2024, section 245I.011, is amended by adding a subdivision to read:

Subd. 6. License required for nonresidential programs. (a) Beginning January 1, 2028, an individual, organization, or government entity must have a license under this chapter to provide the following services:

(1) adult rehabilitative mental health services, as defined in section 256B.0623;

(2) mobile crisis services, as defined in section 256B.0624;

192.1 (3) children's therapeutic services and supports, as defined in section 256B.0943; or

192.2 (4) certified community behavioral health clinic services, as defined in sections 245I.17
192.3 and 256B.0625, subdivision 5m.

192.4 (b) An individual, organization, or government entity certified as any of the following
192.5 must remain certified according to subdivision 5 until the commissioner issues a license,
192.6 the commissioner denies the license application, or the certification expires according to
192.7 chapter 245A:

192.8 (1) an adult rehabilitative mental health services provider under section 256B.0623;

192.9 (2) a mobile crisis team under section 256B.0624;

192.10 (3) a children's therapeutic services and supports provider under section 256B.0943; or

192.11 (4) a certified community behavioral health clinic under section 245.735.

192.12 Sec. 14. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
192.13 to read:

192.14 Subd. 1a. **Alcohol and drug counselor** "Alcohol and drug counselor" means an individual
192.15 qualified under section 245G.11, subdivision 5.

192.16 Sec. 15. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
192.17 to read:

192.18 Subd. 10a. **Comprehensive evaluation.** "Comprehensive evaluation" means a
192.19 person-centered, family-centered, and trauma-informed evaluation conducted according to
192.20 section 245I.17, subdivision 12.

192.21 Sec. 16. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
192.22 to read:

192.23 Subd. 18a. **Initial evaluation.** "Initial evaluation" means the assessment and preliminary
192.24 diagnosis necessary to begin client services, conducted according to section 245I.17.

192.25 Sec. 17. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
192.26 to read:

192.27 Subd. 31a. **Psychotherapy.** "Psychotherapy" has the meaning given in section 256B.0671,
192.28 subdivision 11.

193.1 Sec. 18. Minnesota Statutes 2024, section 245I.02, subdivision 33, is amended to read:

193.2 Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services"
193.3 means mental health services provided to ~~an adult~~ a client that enable the client to develop
193.4 and achieve psychiatric stability, social competencies, personal and emotional adjustment,
193.5 independent living skills, family roles, and community skills when symptoms of mental
193.6 illness has impaired any of the client's abilities in these areas. Rehabilitative mental health
193.7 services include interventions that allow a client to self-monitor, compensate for, counteract,
193.8 or replace psychosocial skills deficits or maladaptive skills acquired over the course of a
193.9 mental illness. For a child client, rehabilitative mental health services include interventions
193.10 to (1) restore a child or adolescent to an age-appropriate developmental trajectory that has
193.11 been disrupted by a psychiatric illness, or (2) enable the child to self-monitor, compensate
193.12 for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills
193.13 acquired over the course of a psychiatric illness.

193.14 Sec. 19. Minnesota Statutes 2024, section 245I.02, subdivision 39, is amended to read:

193.15 Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder
193.16 formulates to respond to a client's needs and goals. A treatment plan includes individual
193.17 treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under
193.18 section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision
193.19 8, and ~~256B.0624, subdivision 11~~ 245I.24, subdivision 11. For a license holder under section
193.20 245I.17, a treatment plan is the integrated treatment plan developed according to section
193.21 245I.17, subdivision 13.

193.22 Sec. 20. Minnesota Statutes 2024, section 245I.03, subdivision 4, is amended to read:

193.23 Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each
193.24 staff person follows when responding to a client who exhibits behavior that threatens the
193.25 immediate safety of the client or others. A license holder's behavioral emergency procedures
193.26 must incorporate person-centered planning and trauma-informed care.

193.27 (b) A license holder's behavioral emergency procedures must include:

- 193.28 (1) a plan designed to prevent the client from inflicting self-harm and harming others;
- 193.29 (2) contact information for emergency resources that a staff person must use when the
193.30 license holder's behavioral emergency procedures are unsuccessful in controlling a client's
193.31 behavior;
- 193.32 (3) the types of behavioral emergency procedures that a staff person may use;

194.1 (4) the specific circumstances under which the program may use behavioral emergency
194.2 procedures; ~~and~~

194.3 (5) the staff persons whom the license holder authorizes to implement behavioral
194.4 emergency procedures; and

194.5 (6) the contact information for the local crisis team.

194.6 (c) The license holder's behavioral emergency procedures must not include secluding
194.7 or restraining a client except as allowed under section 245.8261.

194.8 (d) Staff persons must not use behavioral emergency procedures to enforce program
194.9 rules or for the convenience of staff persons. Behavioral emergency procedures must not
194.10 be part of any client's treatment plan. A staff person may not use behavioral emergency
194.11 procedures except in response to a client's current behavior that threatens the immediate
194.12 safety of the client or others.

194.13 Sec. 21. Minnesota Statutes 2024, section 245I.03, is amended by adding a subdivision
194.14 to read:

194.15 Subd. 11. **Quality assurance and improvement plan.** (a) A license holder must develop
194.16 a written quality assurance and improvement plan that includes plans for:

194.17 (1) encouraging ongoing consultation among members of the treatment team;

194.18 (2) obtaining and evaluating feedback about services from clients, family and other
194.19 natural supports, referral sources, and staff persons;

194.20 (3) measuring and evaluating client outcomes;

194.21 (4) reviewing client suicide deaths and suicide attempts;

194.22 (5) examining the quality of clinical service delivery to clients; and

194.23 (6) self-monitoring of compliance with this chapter.

194.24 (b) At least annually, a license holder must review, evaluate, and update the quality
194.25 assurance and improvement plan. The review must:

194.26 (1) include documentation of the actions that the certification holder will take as a result
194.27 of information obtained from monitoring activities in the plan; and

194.28 (2) establish goals for improved service delivery to clients for the next year.

195.1 Sec. 22. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 5, is amended
195.2 to read:

195.3 Subd. 5. **Behavioral health practitioner scope of practice.** (a) A behavioral health
195.4 practitioner under the treatment supervision of a mental health professional or certified
195.5 rehabilitation specialist may provide an adult client with client education, rehabilitative
195.6 mental health services, functional assessments, level of care assessments, crisis planning,
195.7 and treatment plans. A behavioral health practitioner under the treatment supervision of a
195.8 mental health professional may provide skill-building services ~~to a child client,~~ crisis
195.9 planning, and complete treatment plans for a child client.

195.10 (b) A behavioral health practitioner must not provide treatment supervision to other staff
195.11 persons. A behavioral health practitioner may provide direction to mental health rehabilitation
195.12 workers and mental health behavioral aides.

195.13 (c) A behavioral health practitioner who provides services to clients according to section
195.14 256B.0624 may perform crisis assessments and interventions for a client.

195.15 Sec. 23. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, as amended
195.16 by Laws 2026, chapter 95, article 5, section 14, is amended to read:

195.17 Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment
195.18 supervision of a mental health professional, a mental health behavioral aide may ~~practice~~
195.19 ~~psychosocial skills with~~ provide skill-building services to a child client according to the
195.20 ~~child's treatment plan that a mental health professional, clinical trainee, or behavioral health~~
195.21 ~~practitioner has previously taught to the child.~~

195.22 Sec. 24. Minnesota Statutes 2024, section 245I.06, subdivision 1, is amended to read:

195.23 Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health
195.24 professional or certified rehabilitation specialist provides treatment supervision to each staff
195.25 person who provides services to a client and who is not a mental health professional or
195.26 certified rehabilitation specialist. When providing treatment supervision, a treatment
195.27 supervisor must follow a staff person's written treatment supervision plan.

195.28 (b) Treatment supervision must focus on each client's treatment needs and the ability of
195.29 the staff person under treatment supervision to provide services to each client, including
195.30 the following topics related to the staff person's current caseload:

195.31 (1) a review and evaluation of the interventions that the staff person delivers to each
195.32 client;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) a review and evaluation of each client's assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) instruction on the cultural norms or values of the clients and communities that the license holder serves and the impact that a client's culture has on providing treatment;

(5) evaluation of and feedback regarding a direct service staff person's areas of competency; ~~and~~

(6) coaching, teaching, and practicing skills with a staff person; and

(7) modeling service practices that respect the client, include the client in planning and implementation of the individual treatment plan, recognize the client's strengths, and coordinate with other involved parties and providers.

(c) A treatment supervisor must provide treatment supervision to a staff person using methods that allow for immediate feedback, including in-person, telephone, and interactive video supervision.

(d) A treatment supervisor's responsibility for a staff person receiving treatment supervision is limited to the services provided by the associated license holder. If a staff person receiving treatment supervision is employed by multiple license holders, each license holder is responsible for providing treatment supervision related to the treatment of the license holder's clients.

Sec. 25. Minnesota Statutes 2024, section 245I.06, subdivision 2, is amended to read:

Subd. 2. Treatment supervision planning. (a) A treatment supervisor and the staff person supervised by the treatment supervisor must develop a written treatment supervision plan. The license holder must ensure that a new staff person's treatment supervision plan is completed, approved by the staff person, and implemented by a treatment supervisor and the new staff person within 30 days of the new staff person's first day of employment. The license holder must review and update each staff person's treatment supervision plan annually.

(b) Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the names and licensures of the treatment supervisors who are supervising the staff person;

197.1 (3) how frequently the treatment supervisors must provide treatment supervision to the
197.2 staff person; and

197.3 (4) the staff person's authorized scope of practice, including a description of the client
197.4 ~~population~~ ages that the staff person serves, and a description of the treatment methods and
197.5 modalities that the staff person may use to provide services to clients.

197.6 Sec. 26. Minnesota Statutes 2025 Supplement, section 245I.06, subdivision 3, is amended
197.7 to read:

197.8 Subd. 3. **Treatment supervision and direct observation of mental health**
197.9 **rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral
197.10 aide or a mental health rehabilitation worker must receive direct observation from a mental
197.11 health professional, clinical trainee, certified rehabilitation specialist, or behavioral health
197.12 practitioner while the mental health behavioral aide or mental health rehabilitation worker
197.13 provides treatment services to clients, no less than twice per month for the first six months
197.14 of employment and once per month thereafter. The staff person performing the direct
197.15 observation must approve of the progress note twice per month for the first six months of
197.16 employment and as needed and identified in a supervision plan thereafter. Approval may
197.17 be given through an attestation that is stored in the ~~employee~~ personnel file under section
197.18 245I.07.

197.19 (b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision
197.20 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work
197.21 must at a minimum consist of:

197.22 (1) monthly individual supervision; and

197.23 (2) direct observation twice per month.

197.24 Sec. 27. Minnesota Statutes 2024, section 245I.07, is amended to read:

197.25 **245I.07 PERSONNEL FILES.**

197.26 (a) For each staff person, a license holder must maintain a personnel file that includes:

197.27 (1) verification of the staff person's qualifications required for the position including
197.28 training, education, practicum or internship agreement, licensure, and any other required
197.29 qualifications;

197.30 (2) documentation related to the staff person's background study;

197.31 (3) the hiring date of the staff person;

- 198.1 (4) a description of the staff person's job responsibilities with the license holder;
- 198.2 (5) the date that the staff person's specific duties and responsibilities became effective,
- 198.3 including the date that the staff person began having direct contact with clients;
- 198.4 (6) documentation of the staff person's training as required by section 245I.05, subdivision
- 198.5 2;
- 198.6 (7) a verification copy of license renewals that the staff person completed during the
- 198.7 staff person's employment;
- 198.8 (8) annual job performance evaluations; and
- 198.9 (9) if applicable, the staff person's alleged and substantiated violations of the license
- 198.10 holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license
- 198.11 holder's response.

198.12 (b) The license holder must ensure that all personnel files are readily accessible for the

198.13 commissioner's review. The license holder is not required to keep personnel files in a single

198.14 location.

198.15 (c) For a license holder under section 245I.17, a personnel file for staff who provide

198.16 substance use disorder treatment services must include records of training required under

198.17 section 245G.13, subdivision 2.

198.18 Sec. 28. Minnesota Statutes 2024, section 245I.10, is amended by adding a subdivision

198.19 to read:

198.20 Subd. 2a. **Evaluation, treatment authorization, and planning in a certified community**

198.21 **behavioral health clinic.** Notwithstanding subdivisions 2 and 7, a license holder under

198.22 section 245I.17 must meet the requirements for assessments under section 245I.17,

198.23 subdivisions 11 and 12, and for treatment planning under section 245I.17, subdivision 13.

198.24 Certified community behavioral health clinic service planning and authorization must comply

198.25 with the standards in section 245I.17.

198.26 Sec. 29. Minnesota Statutes 2024, section 245I.10, subdivision 6, as amended by Laws

198.27 2026, chapter 95, article 5, section 15, is amended to read:

198.28 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health

198.29 professional or a clinical trainee may complete a standard diagnostic assessment of a client.

198.30 A standard diagnostic assessment of a client must include a face-to-face interview with a

198.31 client and a written evaluation of the client. The assessor must complete a client's standard

199.1 diagnostic assessment within the client's cultural context. An alcohol and drug counselor
199.2 may gather and document the information in paragraphs (b) and (c) when completing a
199.3 comprehensive assessment according to section 245G.05.

199.4 (b) When completing a standard diagnostic assessment of a client, the assessor must
199.5 gather and document information about the client's current life situation, including the
199.6 following information:

199.7 (1) the client's age;

199.8 (2) the client's current living situation, including the client's housing status and household
199.9 members;

199.10 (3) the status of the client's basic needs;

199.11 (4) the client's education level and employment status;

199.12 (5) the client's current medications;

199.13 (6) any immediate risks to the client's health and safety, including withdrawal symptoms,
199.14 medical conditions, and behavioral and emotional symptoms;

199.15 (7) the client's perceptions of the client's condition;

199.16 (8) the client's description of the client's symptoms, including the reason for the client's
199.17 referral;

199.18 (9) the client's history of mental health and substance use disorder treatment, including
199.19 but not limited to treatment for tobacco or nicotine use;

199.20 (10) cultural influences on the client; and

199.21 (11) substance use history, if applicable, including:

199.22 (i) amounts and types of substances, including but not limited to tobacco and nicotine
199.23 products; frequency and duration; route of administration; periods of abstinence; and
199.24 circumstances of relapse; and

199.25 (ii) the impact to functioning when under the influence of substances, including legal
199.26 interventions.

199.27 (c) If the assessor cannot obtain the information that this paragraph requires without
199.28 retraumatizing the client or harming the client's willingness to engage in treatment, the
199.29 assessor must identify which topics will require further assessment during the course of the
199.30 client's treatment. The assessor must gather and document information related to the following
199.31 topics:

200.1 (1) the client's relationship with the client's family and other significant personal
200.2 relationships, including the client's evaluation of the quality of each relationship;

200.3 (2) the client's strengths and resources, including the extent and quality of the client's
200.4 social networks;

200.5 (3) important developmental incidents in the client's life;

200.6 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

200.7 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

200.8 (6) the client's health history and the client's family health history, including the client's
200.9 physical, chemical, and mental health history.

200.10 (d) When completing a standard diagnostic assessment of a client, an assessor must use
200.11 a recognized diagnostic framework.

200.12 (1) When completing a standard diagnostic assessment of a client who is five years of
200.13 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic
200.14 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
200.15 published by Zero to Three.

200.16 (2) When completing a standard diagnostic assessment of a client who is six years of
200.17 age or older, the assessor must use the current edition of the Diagnostic and Statistical
200.18 Manual of Mental Disorders published by the American Psychiatric Association.

200.19 (3) When completing a standard diagnostic assessment of a client who is 12 to 17 years
200.20 of age, an assessor must use either the CRAFFT Questionnaire or the criteria in the most
200.21 recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by
200.22 the American Psychiatric Association to screen and assess the client for a substance use
200.23 disorder. A license holder may select a different clinically appropriate screening tool if the
200.24 tool is identified in a written policy and procedure under section 245I.03.

200.25 ~~(3)~~ (4) When completing a standard diagnostic assessment of a client who is 18 years
200.26 of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the
200.27 criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental
200.28 Disorders published by the American Psychiatric Association to screen and assess the client
200.29 for a substance use disorder, including but not limited to tobacco use disorder.

200.30 (e) When completing a standard diagnostic assessment of a client, the assessor must
200.31 include and document the following components of the assessment:

200.32 (1) the client's mental status examination;

201.1 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
201.2 vulnerabilities; safety needs, including client information that supports the assessor's findings
201.3 after applying a recognized diagnostic framework from paragraph (d); and any differential
201.4 diagnosis of the client; and

201.5 (3) an explanation of: (i) how the assessor diagnosed the client using the information
201.6 from the client's interview, assessment, psychological testing, and collateral information
201.7 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
201.8 and (v) the client's responsivity factors.

201.9 (f) When completing a standard diagnostic assessment of a client, the assessor must
201.10 consult the client and the client's family about which services that the client and the family
201.11 prefer to treat the client. ~~The assessor must make referrals for the client as to services required~~
201.12 ~~by law.~~

201.13 (g) Information from other providers and prior assessments may be used to complete
201.14 the diagnostic assessment if the source of the information is documented in the diagnostic
201.15 assessment.

201.16 (h) If the client screens positive for a need for substance use disorder treatment services,
201.17 the assessor must document what actions will be taken to address the client's co-occurring
201.18 conditions.

201.19 (i) The assessor must determine if the client is eligible for targeted case management
201.20 services according to section 245.462, subdivision 20, or 245.4871, subdivision 6, and refer
201.21 the client to the county or contracted provider as appropriate.

201.22 Sec. 30. Minnesota Statutes 2024, section 245I.10, subdivision 8, is amended to read:

201.23 Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's
201.24 diagnostic assessment or reviewing a client's diagnostic assessment received from a different
201.25 provider and before providing services to the client beyond those permitted under subdivision
201.26 7, the license holder must complete the client's individual treatment plan. The license holder
201.27 must:

201.28 (1) base the client's individual treatment plan on the client's diagnostic assessment and
201.29 baseline measurements;

201.30 (2) for a child client, use a child-centered, family-driven, and culturally appropriate
201.31 planning process that allows the child's parents and guardians to observe and participate in
201.32 the child's individual and family treatment services, assessments, and treatment planning;

(3) for an adult client, use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning;

(4) identify the client's treatment goals, measureable treatment objectives, a schedule for accomplishing the client's treatment goals and objectives, a treatment strategy, and the individuals responsible for providing treatment services and supports to the client. The license holder must have a treatment strategy to engage the client in treatment if the client:

(i) has a history of not engaging in treatment; and

(ii) is ordered by a court to participate in treatment services or to take neuroleptic medications;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family, case manager, or other natural supports in the client's treatment planning; and

~~(6) review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and goals or, if the client has not made treatment progress, changes in the license holder's approach to treatment; and~~

~~(7)~~ (6) ensure that the client approves of the client's individual treatment plan unless a court orders the client's treatment plan under chapter 253B.

(b) If the client disagrees with the client's treatment plan, the license holder must document in the client file the reasons why the client does not agree with the treatment plan. If the license holder cannot obtain the client's approval of the treatment plan, a mental health professional must make efforts to obtain approval from a person who is authorized to consent on the client's behalf within 30 days after the client's previous individual treatment plan expired. A license holder may not deny a client service during this time period solely because the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

(c) The individual treatment plan must be updated as necessary to reflect the changing needs of the client. The individual treatment plan must include direction for accessing crisis services when the license holder is aware of the client's need for crisis services. The license holder must review the client's individual treatment plan every 180 days and update the

203.1 client's individual treatment plan with the client's treatment progress, new treatment objectives
203.2 and goals, or, if the client has not made treatment progress, changes in the license holder's
203.3 approach to treatment.

203.4 Sec. 31. **[245L.17] CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC**
203.5 **LICENSURE.**

203.6 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this
203.7 subdivision have the meanings given.

203.8 (b) "Care coordination" means the activities required to coordinate care across settings
203.9 and providers for an individual served to ensure seamless transitions across the full spectrum
203.10 of health services. Care coordination includes:

203.11 (1) outreach and engagement;

203.12 (2) documenting a plan of care for medical, behavioral health, and social services and
203.13 supports in the integrated treatment plan;

203.14 (3) assisting with obtaining appointments;

203.15 (4) confirming appointments are kept;

203.16 (5) developing a crisis plan;

203.17 (6) tracking medication; and

203.18 (7) implementing care coordination agreements with external providers. Care coordination
203.19 may include psychiatric consultation with primary care practitioners and with mental health
203.20 clinical care practitioners.

203.21 (c) "CCBHC client" means an individual who has participated in a preliminary triage
203.22 and risk assessment and who has received at least one of the nine required services from a
203.23 CCBHC.

203.24 (d) "Certified community behavioral health clinic" or "CCBHC" means a provider of
203.25 integrated behavioral health services that is licensed under this section and compliant with
203.26 federal CCBHC requirements.

203.27 (e) "Community needs assessment" means an assessment to identify community needs
203.28 and determine the community behavioral health clinic's capacity to address the needs of the
203.29 population being served.

204.1 (f) "Designated collaborating organization" means an entity that is not under the direct
204.2 supervision of a CCBHC engaged in a formal relationship with the CCBHC to deliver one
204.3 or more of the required services or elements of required services.

204.4 (g) "Federal CCBHC criteria" means the most recently issued Certified Community
204.5 Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental
204.6 Health Services Administration.

204.7 (h) "Needs assessment" means the community needs assessment described in federal
204.8 criteria for CCBHC.

204.9 (i) "Preliminary triage and risk assessment" means a mandatory triage and risk assessment
204.10 that is completed at the time of first contact, whether that contact is in person, by telephone,
204.11 or using other remote communication.

204.12 Subd. 2. **Establishment of licensure.** (a) The certified community behavioral health
204.13 clinic model is an integrated service delivery model that uses evidence-based behavioral
204.14 health practices to achieve better outcomes for individuals experiencing behavioral health
204.15 concerns while achieving sustainable rates through cost-based reimbursement for providers
204.16 and economic efficiencies for payors.

204.17 (b) Beginning January 1, 2028, a CCBHC must be licensed under this section.

204.18 (c) A CCBHC must meet the requirements of this section and federal CCBHC criteria.
204.19 The commissioner may require a CCBHC applicant or license holder to submit documentation
204.20 of compliance with state licensing requirements and federal CCBHC criteria.

204.21 (d) The commissioner may deny a license to a CCBHC applicant or license holder on
204.22 the basis of geographic area if a license holder does not meet federal criteria for identifying
204.23 and addressing:

204.24 (1) a community's needs;

204.25 (2) gaps in access to mental health and substance use disorder services; and

204.26 (3) underserved populations to be served by the license holder as outlined in the
204.27 community needs assessment.

204.28 (e) The commissioner shall communicate with licensed CCBHCs, applicants, and
204.29 community partners before establishing and implementing changes in the licensure
204.30 requirements.

204.31 (f) The commissioner shall update state licensing conditions for CCBHCs to align with
204.32 changes to the federal CCBHC criteria. The commissioner may select a transition date on

205.1 which revisions to the federal CCBHC criteria become required as licensing conditions for
205.2 CCBHCs.

205.3 (g) The commissioner shall publish the licensing standards consistent with the most
205.4 recently issued Certified Community Behavioral Health Clinic Certification Criteria published
205.5 by the Substance Abuse and Mental Health Services Administration on a publicly available
205.6 website.

205.7 Subd. 3. **Compliance with federal CCBHC standards.** (a) The commissioner must
205.8 make the required federal attestation of compliance with state and federal standards to the
205.9 Centers for Medicare and Medicaid Services (CMS) upon granting a license meeting all
205.10 requirements of this section.

205.11 (b) The commissioner must renew the required attestation to CMS every 36 months if
205.12 the license holder remains in good standing. If a CCBHC license is revoked during the
205.13 36-month term, the commissioner must publicly report the revocation.

205.14 (c) A license holder that has operated under an existing attestation to CMS for two years
205.15 and three months must submit the documentation required under subdivision 2, paragraph
205.16 (c), to the commissioner.

205.17 (d) The commissioner must complete a licensing review that includes an on-site inspection
205.18 in the six months before the expiration of the federal attestation.

205.19 Subd. 4. **Required services and scope of licensure.** (a) Within a declared service area,
205.20 the CCBHC must be able to offer:

205.21 (1) mobile crisis services, directly or through a designated collaborating organization
205.22 under subdivision 4;

205.23 (2) outpatient mental health and substance use disorder treatment services under
205.24 subdivisions 9 and 10;

205.25 (3) screening, diagnosis, and risk assessment under subdivision 11;

205.26 (4) person- and family-centered treatment planning;

205.27 (5) psychiatric rehabilitation services under subdivision 14;

205.28 (6) community-based mental health care for veterans under subdivision 15;

205.29 (7) outpatient primary care screening and monitoring under subdivision 16;

205.30 (8) peer services under subdivision 17; and

205.31 (9) targeted case management under subdivision 18.

(b) A CCBHC may offer the services listed in paragraph (a) directly or through its designated collaborating organization. The CCBHC must deliver the services in a manner reflecting person- and family-centered care.

Subd. 5. Designated collaborating organization. (a) If a CCBHC is unable to provide mobile crisis services, the CCBHC may contract with another entity that is licensed to provide mobile crisis services under section 245I.24 and that meets the requirements of the federal CCBHC criteria as a designated collaborating organization.

(b) The CCBHC must submit a designated collaborating organization arrangement for approval to the commissioner as part of the licensing process.

(c) The commissioner must not approve a designated collaborating organization agreement under this section to provide services, other than mobile crisis services under section 245I.24, until the commissioner:

(1) implements a mechanism to administer payments for CCBHC services provided under a designated collaborating organization arrangement in a manner that ensures proper payment in compliance with state and federal law; or

(2) determines that the Medicaid Management Information System has the capability to pay for CCBHC services provided under a designated collaborating organization arrangement in compliance with state and federal law.

Subd. 6. Exemptions to host county approval. Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 4, a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Subd. 7. Variances. When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner must consult with stakeholders before granting variances under this provision. For a CCBHC that is licensed but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Subd. 8. **Evidence-based practices.** The commissioner must issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. When developing the list, the commissioner must consider the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practices in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner must provide stakeholders with an opportunity to comment.

Subd. 9. **Outpatient mental health services.** (a) A license holder must provide outpatient mental health services that comply with the federal CCBHC criteria and applicable state standards in this chapter, except as provided in this subdivision.

(b) Completion of an initial or comprehensive evaluation fulfills the requirements to perform a diagnostic assessment in accordance with section 245I.10, subdivisions 2 and 6.

(c) An integrated treatment plan under this section fulfills the requirements to conduct treatment planning in accordance with section 245I.10, subdivisions 7 and 8.

(d) A license holder under this section is exempt from certification as a mental health clinic under section 245I.20.

Subd. 10. **Outpatient substance use disorder treatment.** (a) When a license holder provides substance use disorder treatment services to an individual with a substance use disorder diagnosis, the license holder must comply with the requirements for substance use disorder treatment services in chapter 245G, except as provided in this subdivision.

(b) Completion of a preliminary triage and risk assessment under this section fulfills the requirements to complete an initial services plan under section 245G.04, subdivision 1.

(c) Completion of a comprehensive evaluation under this section fulfills the requirements to administer a comprehensive assessment under section 245G.05.

(d) An integrated treatment plan under this section that contains a six-dimension analysis of the client's needs according to the most recently published edition of the American Society of Addiction Medicine criteria, as defined in section 254B.01, subdivision 2a, fulfills the requirements to provide an individual treatment plan under section 245G.06.

(e) A license holder under this section fulfills the requirement to document personnel files under section 245G.13, subdivision 3, by complying with the requirements of this chapter.

208.1 (f) A license holder under this section fulfills the requirement to protect client rights
208.2 under section 245G.15 by complying with the requirements of section 245I.12.

208.3 (g) A license holder under this section fulfills the requirements to respond to behavioral
208.4 emergencies under section 245G.16 by complying with the requirements of section 245I.03,
208.5 subdivision 4.

208.6 (h) A license holder under this section is exempt from licensure under chapter 245G.

208.7 Subd. 11. **Preliminary triage and risk assessment.** (a) A license holder must have
208.8 policies and procedures on:

208.9 (1) how staff will implement the requirements of this subdivision;

208.10 (2) staff positions authorized to complete triage and risk assessments;

208.11 (3) documenting the results of the risk screenings; and

208.12 (4) ensuring the client is offered timely services according to the federal CCBHC criteria.

208.13 (b) A license holder must conduct a preliminary triage and risk assessment when a new
208.14 client requests services or is referred to services. A license holder may conduct a preliminary
208.15 triage and risk assessment in person, by telephone, or through other remote communication.
208.16 Based on the acuity of needs as assessed in the preliminary triage and risk assessment, the
208.17 client must be categorized as having emergency, urgent, or routine needs.

208.18 (c) Based on these categorizations, the license holder must offer services that meet the
208.19 relevant timelines under the federal CCBHC criteria.

208.20 (d) The license holder must provide training that addresses:

208.21 (1) when a prospective client requires intervention from qualified staff;

208.22 (2) the use of standardized measures that screen for significant risks;

208.23 (3) other factors that indicate a client has urgent needs besides the Columbia Suicide
208.24 Severity Rating Scale or a self-harm screening; and

208.25 (4) overdose and substance use disorder risks.

208.26 Subd. 12. **Initial and comprehensive evaluation.** (a) A license holder under this section
208.27 must provide initial and comprehensive evaluations according to this section and federal
208.28 CCBHC criteria.

208.29 (b) An initial evaluation is necessary to authorize the provision of all medically necessary
208.30 CCBHC services until the completion of a comprehensive evaluation. A comprehensive
208.31 evaluation is necessary to authorize the provision of all medically necessary CCBHC services

209.1 on an ongoing basis. A license holder must ensure that each client's comprehensive evaluation
209.2 reflects the needs and assessments for all services provided.

209.3 Subd. 13. **Integrated treatment plan.** (a) A license holder under this section must
209.4 complete an integrated treatment plan for each client following the client's comprehensive
209.5 evaluation no later than 60 calendar days after the date of the first request for services.

209.6 (b) A license holder must document all required services under subdivision 9 within the
209.7 integrated treatment plan based on the client's needs.

209.8 (c) A license holder must review and update a client's integrated treatment plan as
209.9 necessary to reflect the changing needs of the client and progress made in treatment. If the
209.10 client has not made treatment progress, updates to the treatment plan must indicate changes
209.11 in the license holder's approach to treatment to better meet the needs of the client. A license
209.12 holder must review and update the integrated treatment plan at least every 180 days or as
209.13 clinically indicated.

209.14 Subd. 14. **Psychiatric rehabilitation services.** (a) For children, a license holder under
209.15 this section must provide children's therapeutic services and supports according to section
209.16 245I.30, except that an initial or comprehensive assessment under this section fulfills the
209.17 requirement to perform a standard diagnostic assessment. A license holder under this section
209.18 may elect to provide services according to section 245I.31 under their license.

209.19 (b) For adults, a license holder under this section must provide adult rehabilitative mental
209.20 health services according to section 245I.22, except that:

209.21 (1) the license holder is exempt from the requirement to perform a level of care
209.22 assessment under section 245I.22, subdivision 6, paragraph (b); and

209.23 (2) an initial or comprehensive assessment under this section fulfills the requirement to
209.24 perform a standard diagnostic assessment.

209.25 (c) A license holder under this section is exempt from licensure under sections 245I.22,
209.26 245I.24, 245I.30, and 245I.31.

209.27 Subd. 15. **Community-based care for veterans.** (a) The license holder must provide
209.28 services according to federal requirements for eligibility and coordination with TRICARE
209.29 and the United States Department of Veterans Affairs.

209.30 (b) The license holder must assign and document a principal behavioral health provider
209.31 for every veteran receiving services.

210.1 Subd. 16. **Primary care screening and monitoring.** To fulfill the requirements for
210.2 primary care screening, a license holder under this section must have policies and procedures
210.3 detailing the screenings to be performed with specific populations at the clinic. The policies
210.4 and procedures must be approved by the medical director.

210.5 Subd. 17. **Peer services.** A license holder must be able to provide peer services as
210.6 described by federal CCBHC criteria and sections 245G.07, subdivision 2, clause (8),
210.7 256B.0615, and 256B.0616.

210.8 Subd. 18. **Targeted case management.** (a) A license holder must provide mental health
210.9 targeted case management as described by federal CCBHC criteria and section 256B.0625,
210.10 subdivision 20.

210.11 (b) An initial or comprehensive evaluation under this section fulfills any requirement
210.12 to perform a standard diagnostic assessment for targeted case management.

210.13 Subd. 19. **Community needs assessment.** (a) The applicant or licensed clinic shall
210.14 conduct a community needs assessment every 36 months that meets all requirements outlined
210.15 in the federal criteria.

210.16 (b) An existing license holder must include an analysis of which needs from prior needs
210.17 assessments have been improved by the operation of the CCBHC.

210.18 Subd. 20. **Staffing plan.** (a) Based on an approved community needs assessment, the
210.19 applicant or license holder must complete a staffing plan that is responsive to the community
210.20 needs assessment and meets the federal criteria no less often than every 36 months.

210.21 (b) The commissioner must provide feedback and technical assistance if the commissioner
210.22 determines the license holder must revise the staffing plan.

210.23 Subd. 21. **Data and evaluation.** A provider must submit documentation that establishes
210.24 the ability of the clinic to complete the required data collection as a CCBHC, as determined
210.25 by the commissioner. For an applicant that is an existing provider, the commissioner must
210.26 review and evaluate data submitted related to federal and state CCBHC reporting standards
210.27 to ensure the data meets reporting requirements.

210.28 Subd. 22. **Cost reporting.** A provider must submit a cost report on the forms and in the
210.29 manner required in section 256B.0625, subdivision 5m.

210.30 Subd. 23. **Change of service area or population served.** (a) A CCBHC license holder
210.31 may submit a request to the commissioner to modify the CCBHC's service area or population
210.32 served by submitting updated documentation in a format approved by the commissioner.

211.1 (b) A CCBHC license holder may request a modification under this subdivision no more
211.2 often than once every 12 months.

211.3 (c) The commissioner may deny a license holder's request to change its service area or
211.4 populations under this subdivision if the license holder fails to demonstrate compliance
211.5 with the federal criteria and scope of service requirements under section 223(a)(2)(D) of
211.6 the federal Patient Access to Medicare Act of 2014.

211.7 Sec. 32. [245I.22] ADULT REHABILITATIVE MENTAL HEALTH SERVICES.

211.8 Subdivision 1. Generally. Beginning January 1, 2028, a provider of adult mental health
211.9 rehabilitative services must be licensed under this section and chapter 245A.

211.10 Subd. 2. Definitions. (a) For the purposes of this section, the terms in this subdivision
211.11 have the meanings given.

211.12 (b) "Adult mental health rehabilitative services" or "ARMHS" has the meaning given
211.13 in section 245I.02, subdivision 33.

211.14 (c) "Basic living skills" means rehabilitative interventions that instruct, assist, and support
211.15 the client with:

211.16 (1) interpersonal communication skills;

211.17 (2) community resource utilization and integration skills;

211.18 (3) crisis planning;

211.19 (4) relapse prevention skills;

211.20 (5) health care directives;

211.21 (6) budgeting and shopping skills;

211.22 (7) healthy lifestyle skills and practices;

211.23 (8) cooking and nutrition skills;

211.24 (9) transportation skills;

211.25 (10) mental illness symptom management skills;

211.26 (11) household management skills;

211.27 (12) employment-related skills; and

211.28 (13) parenting skills.

212.1 (d) "Community intervention" means a client's community assisting in the client's
212.2 rehabilitation, including consultation with relatives, guardians, friends, employers, treatment
212.3 providers, and other significant individuals. Community intervention is appropriate when
212.4 directed exclusively to the treatment of the client.

212.5 (e) "Medication education services" means services provided individually or in groups
212.6 that focus on educating the client about mental illness and symptoms, the role and effects
212.7 of medications in treating symptoms of mental illness, and the side effects of medications.
212.8 Medication education services must be coordinated with, but must not duplicate, medication
212.9 management services. Medication education services must be provided by physicians,
212.10 advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

212.11 (f) "Transition to community living services" means services that maintain continuity
212.12 of contact between the ARMHS provider and the client and facilitate discharge from a
212.13 hospital, residential treatment program, board and lodging facility, or nursing home.
212.14 Transition to community living services must not be used to provide other areas of adult
212.15 rehabilitative mental health services.

212.16 Subd. 3. **Service components.** An ARMHS provider must be capable of providing:

212.17 (1) basic living skills;

212.18 (2) medication education services;

212.19 (3) community intervention; and

212.20 (4) transition to community living services.

212.21 Subd. 4. **Provider requirements.** An ARMHS license holder must be enrolled with
212.22 medical assistance and comply with standards in section 256B.0623.

212.23 Subd. 5. **Qualifications.** ARMHS must be provided by:

212.24 (1) a mental health professional qualified under section 245I.04, subdivision 2;

212.25 (2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

212.26 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

212.27 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

212.28 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision
212.29 12; or

212.30 (6) a mental health rehabilitation worker qualified under section 245I.04, subdivision
212.31 14.

213.1 Subd. 6. **Service planning.** (a) An ARMHS provider must complete a written functional
213.2 assessment according to section 245I.10, subdivision 9, for each client.

213.3 (b) When an ARMHS provider completes a written functional assessment, the provider
213.4 must also complete a level of care assessment, as defined in section 245I.02, subdivision
213.5 19, for the client.

213.6 Subd. 7. **Group modality.** ARMHS may be provided in group settings if appropriate
213.7 to each participating client's needs and treatment plan. A group is defined as two to ten
213.8 clients, at least one of whom is concurrently receiving ARMHS. The service and group
213.9 must be specified in the client's individual treatment plan.

213.10 Sec. 33. Minnesota Statutes 2024, section 245I.23, subdivision 4, is amended to read:

213.11 Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the
213.12 license holder must follow a client's treatment plan to provide intensive residential treatment
213.13 services to the client to improve the client's functioning.

213.14 (b) The license holder must offer and have the capacity to directly provide the following
213.15 treatment services to each client:

213.16 (1) daily rehabilitative mental health services;

213.17 (2) crisis prevention planning to assist a client with:

213.18 (i) identifying and addressing patterns in the client's history and experience of the client's
213.19 mental illness; and

213.20 (ii) developing crisis prevention strategies that include de-escalation strategies that have
213.21 been effective for the client in the past;

213.22 (3) health services and administering medication;

213.23 (4) co-occurring substance use disorder treatment;

213.24 (5) engaging the client's family and other natural supports in the client's treatment and
213.25 educating the client's family and other natural supports to strengthen the client's social and
213.26 family relationships; and

213.27 (6) making referrals for the client to other service providers in the community and
213.28 supporting the client's transition from intensive residential treatment services to another
213.29 setting.

214.1 (c) The license holder must include Illness Management and Recovery (IMR), Enhanced
214.2 Illness Management and Recovery (E-IMR), or other similar interventions in the license
214.3 holder's programming as approved by the commissioner.

214.4 Sec. 34. Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

214.5 Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the
214.6 license holder must follow a client's individual crisis treatment plan to provide services to
214.7 the client in residential crisis stabilization to improve the client's functioning.

214.8 (b) The license holder must offer and have the capacity to directly provide the following
214.9 treatment services to the client:

214.10 (1) daily crisis stabilization services as described in section 256B.0624, subdivision 7;

214.11 (2) rehabilitative mental health services;

214.12 (3) health services and administering the client's medications; and

214.13 (4) making referrals for the client to other service providers in the community and
214.14 supporting the client's transition from residential crisis stabilization to another setting.

214.15 Sec. 35. Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 7, is amended
214.16 to read:

214.17 Subd. 7. **Intensive residential treatment services assessment and treatment**
214.18 **planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and
214.19 document the client's immediate needs, including the client's:

214.20 (1) health and safety, including the client's need for crisis assistance;

214.21 (2) responsibilities for children, family and other natural supports, and employers; and

214.22 (3) housing and legal issues.

214.23 (b) Within 24 hours of the client's admission, the license holder must complete an initial
214.24 treatment plan for the client. The license holder must:

214.25 (1) base the client's initial treatment plan on the client's referral information and an
214.26 assessment of the client's immediate needs;

214.27 (2) consider crisis assistance strategies that have been effective for the client in the past;

214.28 (3) identify the client's initial treatment goals, measurable treatment objectives, and
214.29 specific interventions, and the frequency of interventions, that the license holder will use
214.30 to help the client engage in treatment;

215.1 (4) identify the participants involved in the client's treatment planning. The client must
215.2 be a participant; and

215.3 (5) ensure that a treatment supervisor approves of the client's initial treatment plan if a
215.4 behavioral health practitioner or clinical trainee completes the client's treatment plan,
215.5 notwithstanding section 245I.08, subdivision 3.

215.6 (c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must
215.7 complete an individual abuse prevention plan as part of a client's initial treatment plan.

215.8 (d) Within five days of the client's admission and again within 60 days after the client's
215.9 admission, the license holder must complete a level of care assessment of the client. If the
215.10 license holder determines that a client does not need a medically monitored level of service,
215.11 a treatment supervisor must document how the client's admission to and continued services
215.12 in intensive residential treatment services are medically necessary for the client.

215.13 (e) Within ten days of a client's admission, the license holder must complete or review
215.14 and update the client's standard diagnostic assessment.

215.15 (f) Within ten days of a client's admission, the license holder must complete the client's
215.16 individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days
215.17 after the client's admission and again within 70 days after the client's admission, the license
215.18 holder must update the client's individual treatment plan. The license holder must focus the
215.19 client's treatment planning on preparing the client for a successful transition from intensive
215.20 residential treatment services to another setting. The individual treatment plan must be based
215.21 on the client's diagnostic assessment and functional assessment and must contain, at a
215.22 minimum, identified goals according to subdivision 4, paragraph (b), clauses (1) to (3), or
215.23 subdivision 5, paragraph (b), clause (1), as applicable. In addition to the required elements
215.24 of an individual treatment plan under section 245I.10, subdivision 8, the license holder must
215.25 identify the following information in the client's individual treatment plan: (1) the client's
215.26 referrals and resources for the client's health and safety; and (2) the staff persons who are
215.27 responsible for following up with the client's referrals and resources. If the client does not
215.28 receive a referral or resource that the client needs, the license holder must document the
215.29 reason that the license holder did not make the referral or did not connect the client to a
215.30 particular resource. The license holder is responsible for determining whether additional
215.31 follow-up is required on behalf of the client.

215.32 (g) Within 30 days of the client's admission, the license holder must complete a functional
215.33 assessment of the client. Within 60 days after the client's admission, the license holder must

216.1 update the client's functional assessment to include any changes in the client's functioning
216.2 and symptoms.

216.3 (h) For a client with a current substance use disorder diagnosis and for a client whose
216.4 substance use disorder screening in the client's standard diagnostic assessment indicates the
216.5 possibility that the client has a substance use disorder, the license holder must complete a
216.6 written assessment of the client's substance use within 30 days of the client's admission. In
216.7 the substance use assessment, the license holder must: (1) evaluate the client's history of
216.8 substance use, relapses, and hospitalizations related to substance use; (2) assess the effects
216.9 of the client's substance use on the client's relationships including with family member and
216.10 others; (3) identify financial problems, health issues, housing instability, and unemployment;
216.11 (4) assess the client's legal problems, past and pending incarceration, violence, and
216.12 victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking
216.13 prescribed medications, and noncompliance with psychosocial treatment.

216.14 (i) On a weekly basis, a mental health professional or certified rehabilitation specialist
216.15 must review each client's treatment plan and individual abuse prevention plan. The license
216.16 holder must document in the client's file each weekly review of the client's treatment plan
216.17 and individual abuse prevention plan. An individual treatment plan must be updated based
216.18 on new information gathered about the client's conditions, the client's level of participation,
216.19 and whether identified interventions have had the intended effect.

216.20 Sec. 36. Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 10, is amended
216.21 to read:

216.22 Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder
216.23 must maintain a treatment team staffing level sufficient to:

216.24 (1) provide continuous daily coverage of all shifts;

216.25 (2) follow each client's treatment plan and meet each client's needs as identified in the
216.26 client's treatment plan;

216.27 (3) implement program requirements; and

216.28 (4) safely monitor and guide the activities of each client, taking into account the client's
216.29 level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

216.30 (b) The license holder must ensure that treatment team members:

216.31 (1) remain awake during all work hours; and

217.1 (2) are available to monitor and guide the activities of each client whenever clients are
217.2 present in the program.

217.3 (c) On each shift, the license holder must maintain a treatment team staffing ratio of at
217.4 least one treatment team member to nine clients. If the license holder is serving nine or
217.5 fewer clients, at least one treatment team member on the day shift must be a mental health
217.6 professional, clinical trainee, certified rehabilitation specialist, or behavioral health
217.7 practitioner. If the license holder is serving more than nine clients, at least one of the
217.8 treatment team members working during both the day and evening shifts must be a mental
217.9 health professional, clinical trainee, certified rehabilitation specialist, or behavioral health
217.10 practitioner.

217.11 (d) If the license holder provides residential crisis stabilization to clients and is serving
217.12 at least one client in residential crisis stabilization and more than four clients in residential
217.13 crisis stabilization and intensive residential treatment services, the license holder must
217.14 maintain a treatment team staffing ratio on each shift of at least two treatment team members
217.15 during the client's first 48 hours in residential crisis stabilization.

217.16 (e) The license holder must maintain documentation of a daily staffing schedule indicating
217.17 the names and credentials of individuals providing services, according to the record retention
217.18 requirements under section 245A.041.

217.19 Sec. 37. Minnesota Statutes 2024, section 245I.23, subdivision 12, is amended to read:

217.20 Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program,
217.21 the license holder must provide a daily summary in the client's file that includes observations
217.22 about the client's behavior and symptoms, including any critical incidents in which the client
217.23 was involved, and documentation of a daily medically necessary rehabilitation service
217.24 according to section 245I.08.

217.25 (b) For each day that a client is not present in the program, the license holder must
217.26 document the reason for a client's absence in the client's file.

217.27 Sec. 38. Minnesota Statutes 2024, section 245I.23, subdivision 17, is amended to read:

217.28 Subd. 17. **Admissions referrals and determinations.** (a) The license holder must
217.29 identify the information that the license holder needs to make a determination about a
217.30 person's admission referral.

217.31 (b) The license holder must:

218.1 (1) always be available to receive referral information about a person seeking admission
218.2 to the license holder's program;

218.3 (2) respond to the referral source within eight hours of receiving a referral and, within
218.4 eight hours, communicate with the referral source about what information the license holder
218.5 needs to make a determination concerning the person's admission;

218.6 (3) consider the license holder's staffing ratio and the areas of treatment team members'
218.7 competency when determining whether the license holder is able to meet the needs of a
218.8 person seeking admission; ~~and~~

218.9 (4) determine whether to admit a person within 72 hours of receiving all necessary
218.10 information from the referral source; and

218.11 (5) document client eligibility according to subdivision 15, paragraph (a), and subdivision
218.12 16.

218.13 Sec. 39. **[245L.24] MOBILE CRISIS RESPONSE SERVICES.**

218.14 Subdivision 1. Generally. (a) Mobile crisis response services provide short-term,
218.15 face-to-face mental health care in community settings for adults and children experiencing
218.16 crisis to help individuals maintain safety and return to a baseline level of functioning.

218.17 (b) Beginning January 1, 2028, a provider of mobile crisis response services must be
218.18 licensed under this section and chapter 245A.

218.19 Subd. 2. Definitions. (a) For the purposes of this section, the terms in this subdivision
218.20 have the meanings given.

218.21 (b) "Crisis assessment" means an immediate face-to-face assessment by a physician, a
218.22 mental health professional, or a qualified member of a crisis team, as described in subdivision
218.23 5.

218.24 (c) "Crisis intervention" means face-to-face, short-term intensive mental health services
218.25 initiated during a mental health crisis to help an individual cope with immediate stressors,
218.26 identify and utilize available resources and strengths, engage in voluntary treatment, and
218.27 begin to return to the individual's baseline level of functioning.

218.28 (d) "Crisis screening" means a screening of a client's potential mental health crisis
218.29 situation under subdivision 6.

218.30 (e) "Crisis stabilization services" means individualized mental health services that are
218.31 designed to restore an individual to the individual's baseline level of functioning. Crisis
218.32 stabilization services may be provided in the individual's home, the home of a family member

219.1 or friend of the individual, another community setting, a short-term supervised licensed
219.2 residential program, or an emergency department. Crisis stabilization services include family
219.3 psychoeducation.

219.4 (f) "Crisis team" means the staff of a provider entity who are supervised and prepared
219.5 to provide mobile crisis services to a client in a potential mental health crisis situation.

219.6 (g) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without
219.7 the provision of crisis response services, would likely result in significantly reducing the
219.8 individual's levels of functioning in primary activities of daily living, the individual needing
219.9 emergency services under section 62Q.55, or the individual being placed in a more restrictive
219.10 setting, including but not limited to inpatient hospitalization.

219.11 (h) "Mobile crisis services" means screening, assessment, intervention, and
219.12 community-based crisis stabilization services that are provided to an individual client.
219.13 Mobile crisis services does not include residential crisis stabilization.

219.14 Subd. 3. **Eligibility.** (a) An individual is eligible for crisis assessment services when the
219.15 person has screened positive for a potential mental health crisis during a crisis screening.

219.16 (b) An individual is eligible for crisis intervention services and crisis stabilization services
219.17 when the individual has been assessed during a crisis assessment to be experiencing a mental
219.18 health crisis.

219.19 Subd. 4. **Policies, procedures, and practices specified.** (a) In addition to the policies
219.20 and procedures required by section 245I.03, the license holder must establish, enforce, and
219.21 maintain policies and procedures to:

219.22 (1) ensure that crisis screenings, crisis assessments, and crisis intervention services are
219.23 available 24 hours per day, seven days per week;

219.24 (2) respond to a call for services in a designated service area or according to a written
219.25 agreement with the local mental health authority for an adjacent area;

219.26 (3) have at least one mental health professional on staff at all times and at least one
219.27 additional staff member capable of leading a crisis response in the community; and

219.28 (4) respond to clients in the community according to the requirements and priorities in
219.29 subdivision 6.

219.30 (b) The license holder must provide the commissioner with information about the number
219.31 of requests for service, the number of clients that the provider serves face-to-face, and client
219.32 outcomes at least every six months, in a form and manner prescribed by the commissioner.

220.1 (c) The license holder must:

220.2 (1) provide support for an individual's family and natural supports by enabling the
220.3 individual's family and natural supports to observe and participate in the individual's
220.4 treatment, assessments, and planning services;

220.5 (2) implement culturally specific treatment identified in the crisis treatment plan that is
220.6 meaningful and appropriate, as determined by the individual's culture, beliefs, values, and
220.7 language;

220.8 (3) respond to an individual's changing intervention and care needs, as identified by the
220.9 individual or a family member; and

220.10 (4) have the communication tools and procedures to communicate and consult promptly
220.11 about crisis assessment and interventions as services are provided.

220.12 (d) The license holder must coordinate services with:

220.13 (1) county emergency services under section 245.469, community hospitals, ambulance
220.14 services, transportation services, social services, law enforcement, engagement services,
220.15 and mental health crisis services through regularly scheduled interagency meetings;

220.16 (2) other behavioral health service providers, county mental health authorities, or federally
220.17 recognized American Indian authorities, and others as necessary, with the consent of the
220.18 individual or parent or guardian;

220.19 (3) detoxification, withdrawal management services, and medical stabilization services
220.20 as needed; and

220.21 (4) the individual's case manager if the individual is receiving case management services.

220.22 Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Crisis assessment
220.23 and intervention services must be provided by:

220.24 (1) a mental health professional qualified under section 245I.04, subdivision 2;

220.25 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

220.26 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

220.27 (4) a mental health certified family peer specialist qualified under section 245I.04,
220.28 subdivision 12; or

220.29 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision
220.30 10.

221.1 (b) When crisis assessment and intervention services are provided to an individual in
221.2 the community, a mental health professional, clinical trainee, or mental health practitioner
221.3 must lead the response.

221.4 (c) For providers under this section, the 30 hours of ongoing training required by section
221.5 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children
221.6 and adults and include training about evidence-based practices identified by the commissioner
221.7 of health to reduce the individual's risk of suicide and self-injurious behavior.

221.8 (d) At least six hours of the ongoing training under paragraph (c) must be specific to
221.9 working with families and providing crisis stabilization services to children and include the
221.10 following topics:

221.11 (1) developmental tasks of childhood and adolescence;

221.12 (2) family relationships;

221.13 (3) child and youth engagement and motivation, including motivational interviewing;

221.14 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
221.15 queer youth;

221.16 (5) positive behavior support;

221.17 (6) crisis intervention for youth with developmental disabilities;

221.18 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
221.19 therapy; and

221.20 (8) youth substance use.

221.21 (e) Individual providers must be experienced in crisis assessment, crisis intervention
221.22 techniques, treatment engagement strategies, working with families, and clinical decision
221.23 making under emergency conditions and have knowledge of local services and resources.

221.24 Subd. 6. **Crisis screening.** (a) A license holder may use the resources of emergency
221.25 services under section 245.469 for crisis screening. The crisis screening must gather
221.26 information, determine whether a mental health crisis situation exists, identify parties
221.27 involved, and determine an appropriate response.

221.28 (b) When conducting a crisis screening, a provider must:

221.29 (1) employ evidence-based practices to reduce the individual's risk of suicide and
221.30 self-injurious behavior;

222.1 (2) work with the individual to establish a plan and time frame for responding to the
222.2 individual's mental health crisis, including responding to the individual's immediate need
222.3 for support by telephone or text message until the provider can respond to the individual
222.4 face-to-face;

222.5 (3) document significant factors in determining whether the individual is experiencing
222.6 a mental health crisis, including prior requests for crisis services, an individual's recent
222.7 presentation at an emergency department, known calls to 911 or law enforcement, or
222.8 information from third parties with knowledge of an individual's history or current needs;

222.9 (4) accept calls from interested third parties and consider the additional needs or potential
222.10 mental health crises that the third parties may be experiencing;

222.11 (5) provide psychoeducation, including reducing access to means of suicide, to relevant
222.12 third parties including family members or other persons living with the individual; and

222.13 (6) consider other available services to determine which service intervention would best
222.14 address the individual's needs and circumstances.

222.15 (c) For the purposes of this section, the following situations indicate a positive screen
222.16 for a potential mental health crisis:

222.17 (1) the individual presents at an emergency department or urgent care setting and the
222.18 health care team at that location requested crisis services; or

222.19 (2) a peace officer requested crisis services for an individual who is potentially subject
222.20 to transportation under section 253B.051.

222.21 (d) The provider must prioritize providing a face-to-face crisis assessment of the
222.22 individual, unless a provider documents specific evidence to show why the face-to-face
222.23 assessment was not possible, including insufficient staffing resources, concerns for staff or
222.24 individual safety, or other clinical factors.

222.25 (e) A provider is not required to have direct contact with the individual to determine
222.26 that the individual is experiencing a potential mental health crisis. A mobile crisis provider
222.27 may gather relevant information about the individual from a third party to establish the
222.28 individual's need for services and potential safety factors.

222.29 Subd. 7. **Crisis assessment.** (a) If an individual screens positive for a potential mental
222.30 health crisis, a crisis assessment must be completed. A crisis assessment must evaluate any
222.31 immediate needs for which services are needed and, as time permits, the individual's:

222.32 (1) current life situation;

- 223.1 (2) health information, including current medications;
- 223.2 (3) sources of stress;
- 223.3 (4) mental health problems and symptoms;
- 223.4 (5) strengths;
- 223.5 (6) cultural considerations;
- 223.6 (7) support network;
- 223.7 (8) vulnerabilities;
- 223.8 (9) current functioning; and
- 223.9 (10) preferences, as communicated directly by the individual or as communicated in a
- 223.10 health care directive as described in chapters 145C and 253B, the crisis treatment plan
- 223.11 described in subdivision 11, a crisis prevention plan, or a wellness recovery action plan.
- 223.12 (b) A provider must conduct a crisis assessment at the individual's location when
- 223.13 appropriate and, when not appropriate, document the reasons.
- 223.14 (c) Whenever possible, the assessor must attempt to include input from the individual,
- 223.15 the individual's family, and other natural supports to assess whether a crisis exists.
- 223.16 (d) A crisis assessment must include a determination of:
- 223.17 (1) whether the individual is willing to voluntarily engage in treatment;
- 223.18 (2) whether the individual has an advance directive; and
- 223.19 (3) gathering the individual's information and history from involved family or other
- 223.20 natural supports.
- 223.21 (e) If a team determines that the individual does not need an acute level of care, the team
- 223.22 must provide services or service coordination if the individual has a co-occurring substance
- 223.23 use disorder and is otherwise eligible for services.
- 223.24 (f) If, after completing a crisis assessment, a provider refers the individual to an intensive
- 223.25 setting, including an emergency department, inpatient hospitalization, or residential crisis
- 223.26 stabilization, one of the crisis team members who completed or conferred about the
- 223.27 individual's crisis assessment must immediately contact the referral entity and consult with
- 223.28 the staff responsible for triage or intake at the referral entity. During the consultation, the
- 223.29 crisis team member must convey key findings or concerns that led to the individual's referral.
- 223.30 Following the consultation, the provider must also send written documentation to the referral

224.1 entity. The provider must document if the individual or the individual's legal guardian signed
224.2 releases for health records or if an exception under section 144.293, subdivision 5, exists.

224.3 Subd. 8. **Crisis intervention services.** (a) If the crisis assessment determines an individual
224.4 needs mobile crisis intervention services, the license holder must provide crisis intervention
224.5 services promptly. As able during the intervention, at least two members of the mobile crisis
224.6 intervention team must confer directly or by telephone about the crisis assessment, crisis
224.7 treatment plan, and actions taken and needed. At least one of the team members must be
224.8 providing face-to-face crisis intervention services. If providing crisis intervention services,
224.9 a clinical trainee or mental health practitioner must seek treatment supervision as required
224.10 in subdivision 10.

224.11 (b) If a provider delivers crisis intervention services while the individual is absent, the
224.12 provider must document the reason for delivering services while the individual is absent.

224.13 (c) The mobile crisis intervention team must develop a crisis treatment plan according
224.14 to subdivision 11.

224.15 (d) The mobile crisis intervention team must document which crisis treatment plan goals
224.16 and objectives have been met and when no further crisis intervention services are required.

224.17 (e) If the individual's mental health crisis is stabilized, but the individual needs a referral
224.18 to other services, the team must provide referrals to these services. If the individual is unable
224.19 to follow up on the referral, the team must link the individual to the service and follow up
224.20 to ensure the individual is receiving the service.

224.21 Subd. 9. **Crisis stabilization services.** (a) Crisis stabilization services must be provided
224.22 by qualified staff of a crisis stabilization services provider entity, which must:

224.23 (1) develop a crisis treatment plan that meets the criteria in subdivision 11;

224.24 (2) complete a vulnerable adult determination in accordance with section 245A.65,
224.25 subdivision 1a;

224.26 (3) deliver crisis stabilization services according to the crisis treatment plan and include
224.27 face-to-face contact with the individual receiving services by qualified staff for further
224.28 assessment, help with referrals, updating of the crisis treatment plan, skills training, and
224.29 collaboration with other service providers in the community;

224.30 (4) if the provider delivers crisis stabilization services while the individual is absent,
224.31 document the reason for delivering services while the individual is absent; and

225.1 (5) if the individual's mental health crisis is stabilized and the individual does not have
225.2 a health care directive or psychiatric declaration, as defined in chapter 145C or section
225.3 253B.03, subdivision 6d, offer to work with the individual to develop a directive or
225.4 declaration.

225.5 (b) A staff member providing crisis stabilization services must be:

225.6 (1) a mental health professional qualified under section 245I.04, subdivision 2;

225.7 (2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

225.8 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

225.9 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

225.10 (5) a mental health certified family peer specialist qualified under section 245I.04,
225.11 subdivision 12;

225.12 (6) a mental health certified peer specialist qualified under section 245I.04, subdivision
225.13 10; or

225.14 (7) a mental health rehabilitation worker qualified under section 245I.04, subdivision
225.15 14.

225.16 (c) For providers under this section, the 30 hours of ongoing training required in section
225.17 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children
225.18 and adults and include training about evidence-based practices identified by the commissioner
225.19 of health to reduce an individual's risk of suicide and self-injurious behavior.

225.20 (d) For providers who deliver care to children 21 years of age or younger, at least six
225.21 hours of the ongoing training under this subdivision must be specific to working with families
225.22 and providing crisis stabilization services to children, including the following topics:

225.23 (1) developmental tasks of childhood and adolescence;

225.24 (2) family relationships;

225.25 (3) child and youth engagement and motivation, including motivational interviewing;

225.26 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
225.27 queer youth;

225.28 (5) positive behavior support;

225.29 (6) crisis intervention for youth with developmental disabilities;

226.1 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
226.2 therapy; and

226.3 (8) youth substance use.

226.4 This paragraph does not apply to adult residential crisis stabilization services providers
226.5 licensed under section 245I.23 or providing services pursuant to section 256B.0624,
226.6 subdivision 7a.

226.7 Subd. 10. **Supervision.** Clinical trainees and mental health practitioners may provide
226.8 crisis assessment and crisis intervention services if the following treatment supervision
226.9 requirements are met:

226.10 (1) the license holder must accept full responsibility for the services provided;

226.11 (2) a mental health professional working for the license holder must be immediately
226.12 available by telephone or in person for treatment supervision;

226.13 (3) a mental health professional must be consulted, in person or by telephone, during
226.14 the first three hours when a clinical trainee or mental health practitioner provides crisis
226.15 assessment or crisis intervention services; and

226.16 (4) a mental health professional must:

226.17 (i) review and approve, as defined in section 245I.02, subdivision 2, the tentative crisis
226.18 assessment and crisis treatment plan within 24 hours of first providing services to the
226.19 individual, notwithstanding section 245I.08, subdivision 3; and

226.20 (ii) document the consultation required in clause (3).

226.21 Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of an individual's admission, the
226.22 license holder must complete the individual's crisis treatment plan. The license holder must:

226.23 (1) base the individual's crisis treatment plan on the individual's crisis assessment;

226.24 (2) consider crisis assistance strategies that have been effective for the individual in the
226.25 past;

226.26 (3) for a child, use a child-centered, family-driven, and culturally appropriate planning
226.27 process that allows the child's parents and guardians to observe or participate in the child's
226.28 individual and family treatment services, assessment, and treatment planning;

226.29 (4) for an adult, use a person-centered, culturally appropriate planning process that allows
226.30 the individual's family and other natural supports to observe or participate in treatment
226.31 services, assessment, and treatment planning;

227.1 (5) identify the participants involved in the individual's treatment planning. The individual
227.2 must be a participant if possible;

227.3 (6) identify the individual's initial treatment goals, measurable treatment objectives, and
227.4 specific interventions that the license holder will use to help the person engage in treatment;

227.5 (7) include documentation of referral to and scheduling of services, including specific
227.6 providers where applicable;

227.7 (8) ensure that the individual or the individual's legal guardian approves under section
227.8 245I.02, subdivision 2, of the individual's crisis treatment plan unless a court orders the
227.9 individual's treatment plan under chapter 253B. If the individual or the individual's legal
227.10 guardian disagrees with the crisis treatment plan, the license holder must document in the
227.11 client file the reasons why the individual disagrees with the crisis treatment plan; and

227.12 (9) ensure that a treatment supervisor approves, as defined in section 245I.02, subdivision
227.13 2, of the individual's treatment plan within 24 hours of the individual's admission if a mental
227.14 health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding
227.15 section 245I.08, subdivision 3.

227.16 (b) The provider entity must provide the individual and the individual's legal guardian
227.17 with a copy of the crisis treatment plan.

227.18 Subd. 12. **Application requirements.** In a licensing application submitted under this
227.19 section and section 245A.04, the applicant must demonstrate that the applicant is:

227.20 (1) enrolled as a medical assistance provider; and

227.21 (2) in compliance with the provider type requirements under section 256B.0624,
227.22 subdivision 4, as determined by the commissioner.

227.23 Sec. 40. **[245I.30] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

227.24 Subdivision 1. **Generally.** (a) "Children's therapeutic services and supports" means a
227.25 flexible package of community-based mental health services for children who require varying
227.26 therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness.
227.27 Interventions are delivered using various treatment modalities and combinations of services
227.28 designed to reach treatment outcomes identified in the individual treatment plan. Children's
227.29 therapeutic services and supports include development and rehabilitative services that
227.30 support a child's developmental treatment needs.

227.31 (b) Beginning January 1, 2028, a provider of children's therapeutic services and supports
227.32 must be licensed under this section and chapter 245A.

228.1 Subd. 2. **Service components.** (a) A children's therapeutic services and supports license
228.2 holder must be capable of providing:

228.3 (1) individual and family psychotherapy, psychotherapy for crises, and group
228.4 psychotherapy;

228.5 (2) individual, family, or group skills training; and

228.6 (3) crisis planning.

228.7 (b) Crisis planning that meets the standards in section 245.4871, subdivision 9a, must
228.8 be offered to each client's family.

228.9 Subd. 3. **Provider requirements.** A children's therapeutic services and supports license
228.10 holder must be enrolled with medical assistance and comply with the requirements in section
228.11 256B.0943.

228.12 Subd. 4. **Qualifications of provider staff.** Children's therapeutic services and supports
228.13 must be provided by:

228.14 (1) a mental health professional qualified under section 245I.04, subdivision 2;

228.15 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

228.16 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

228.17 (4) a mental health certified family peer specialist qualified under section 245I.04,
228.18 subdivision 12; or

228.19 (5) a mental health behavioral aide qualified under section 245I.04, subdivision 16.

228.20 Subd. 5. **Group modality.** Group skills training may be provided to multiple clients
228.21 who, because of the nature of the clients' emotional, behavioral, or social dysfunction, can
228.22 derive mutual benefit from interaction in a group setting. A group must consist of two to
228.23 ten clients, at least one of whom is a client and is concurrently receiving a service under
228.24 this section. The service and group must be specified in the client's individual treatment
228.25 plan.

228.26 Sec. 41. **[245I.31] CHILDREN'S DAY TREATMENT.**

228.27 Subdivision 1. **Generally.** (a) For the purposes of this section, "children's day treatment
228.28 program" means a site-based structured mental health program consisting of psychotherapy
228.29 and individual or group skills training provided by a team under the treatment supervision
228.30 of a mental health professional.

229.1 (b) A children's day treatment program must be licensed for a specific location of
229.2 operation and must not be part of inpatient or residential treatment services.

229.3 (c) A children's day treatment program must stabilize a client's mental health status while
229.4 developing and improving the client's independent living and socialization skills. The goal
229.5 of the day treatment program must be to reduce or relieve the effects of mental illness and
229.6 provide training to enable the client to live in the community.

229.7 (d) Beginning January 1, 2028, a provider of children's day services must be licensed
229.8 under this section and chapter 245A.

229.9 Subd. 2. **Service components.** A children's day treatment program must be capable of
229.10 providing the services in section 245I.30, subdivision 2.

229.11 Subd. 3. **Provider requirements.** A children's day treatment license holder must:

229.12 (1) be enrolled as a provider with medical assistance;

229.13 (2) maintain a policy regarding the use of restrictive procedures and meet the requirements
229.14 of section 245.8261;

229.15 (3) maintain a policy on medications in accordance with section 245I.11, subdivision
229.16 6; and

229.17 (4) meet group modality requirements in section 245I.30, subdivision 5.

229.18 Subd. 4. **Qualifications of provider staff.** Children's day treatment services must be
229.19 provided by:

229.20 (1) a mental health professional qualified under section 245I.04, subdivision 2;

229.21 (2) a clinical trainee qualified under section 245I.04, subdivision 6; or

229.22 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4.

229.23 Sec. 42. Minnesota Statutes 2024, section 256B.0623, subdivision 1, is amended to read:

229.24 Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically
229.25 necessary adult rehabilitative mental health services when the services are provided by an
229.26 entity ~~meeting the standards in this section~~ licensed under section 245I.24. The provider
229.27 entity must make reasonable and good faith efforts to report individual client outcomes to
229.28 the commissioner, using instruments and protocols approved by the commissioner.

229.29 Sec. 43. Minnesota Statutes 2024, section 256B.0623, subdivision 3, is amended to read:

229.30 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

230.1 (1) is age 18 or older;

230.2 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain
230.3 injury, for which adult rehabilitative mental health services are needed;

230.4 (3) has substantial disability and functional impairment in three or more of the areas
230.5 listed in section 245I.10, subdivision 9, paragraph (a), clause (4), so that self-sufficiency is
230.6 markedly reduced; and

230.7 (4) has had a recent standard diagnostic assessment pursuant to section 245I.10,
230.8 subdivision 6, by a qualified professional that documents adult rehabilitative mental health
230.9 services are medically necessary to address identified disability and functional impairments
230.10 and individual recipient goals.

230.11 Sec. 44. Minnesota Statutes 2024, section 256B.0623, subdivision 12, is amended to read:

230.12 Subd. 12. **Additional requirements.** ~~(a) Providers of adult rehabilitative mental health~~
230.13 ~~services must comply with the requirements relating to referrals for case management in~~
230.14 ~~section 245.467, subdivision 4.~~

230.15 ~~(b) Adult rehabilitative mental health services are provided for most recipients in the~~
230.16 ~~recipient's home and community. Services may also be provided at the home of a relative~~
230.17 ~~or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,~~
230.18 ~~or other places in the community. (a) Except for "transition to community services," the~~
230.19 place of service does not include a regional treatment center, nursing home, residential
230.20 treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36),
230.21 or section 245I.23, or an acute care hospital.

230.22 ~~(c) Adult rehabilitative mental health services may be provided in group settings if~~
230.23 ~~appropriate to each participating recipient's needs and individual treatment plan. A group~~
230.24 ~~is defined as two to ten clients, at least one of whom is a recipient, who is concurrently~~
230.25 ~~receiving a service which is identified in this section. The service and group must be specified~~
230.26 ~~in the recipient's individual treatment plan. (b) No more than two qualified staff may bill~~
230.27 Medicaid for services provided to the same group of recipients. If two adult rehabilitative
230.28 mental health workers bill for recipients in the same group session, they must each bill for
230.29 different recipients.

230.30 ~~(d)~~ (c) Adult rehabilitative mental health services are appropriate if provided to enable
230.31 a recipient to retain stability and functioning, when the recipient is at risk of significant
230.32 functional decompensation or requiring more restrictive service settings without these
230.33 services.

231.1 ~~(e) Adult rehabilitative mental health services instruct, assist, and support the recipient~~
231.2 ~~in areas including: interpersonal communication skills, community resource utilization and~~
231.3 ~~integration skills, crisis planning, relapse prevention skills, health care directives, budgeting~~
231.4 ~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,~~
231.5 ~~transportation skills, medication education and monitoring, mental illness symptom~~
231.6 ~~management skills, household management skills, employment-related skills, parenting~~
231.7 ~~skills, and transition to community living services.~~

231.8 ~~(f) Community intervention, including consultation with relatives, guardians, friends,~~
231.9 ~~employers, treatment providers, and other significant individuals, is appropriate when~~
231.10 ~~directed exclusively to the treatment of the client.~~

231.11 Sec. 45. Minnesota Statutes 2024, section 256B.0624, subdivision 1, is amended to read:

231.12 Subdivision 1. **Scope.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically
231.13 necessary crisis response services when the services are provided according to the standards
231.14 in ~~this section~~ 245I.24.

231.15 (b) ~~Subject to federal approval,~~ Medical assistance covers medically necessary residential
231.16 crisis stabilization for adults when the services are provided by an entity licensed under and
231.17 meeting the standards in section 245I.23 or an entity with an adult foster care license meeting
231.18 the standards in ~~this section~~ subdivision 7a.

231.19 (c) The provider entity must make reasonable and good faith efforts to report individual
231.20 client outcomes to the commissioner using instruments and protocols approved by the
231.21 commissioner.

231.22 Sec. 46. Minnesota Statutes 2024, section 256B.0624, subdivision 4, as amended by Laws
231.23 2026, chapter 88, article 1, section 123, is amended to read:

231.24 Subd. 4. **Provider entity standards.** (a) A mobile crisis provider must be:

231.25 (1) a county board operated entity;

231.26 (2) an Indian health services facility or facility owned and operated by a tribe or Tribal
231.27 organization operating under United States Code, title 325, section 450f; or

231.28 (3) a provider entity that is under contract with the county board in the county where
231.29 the potential crisis or emergency is occurring. To provide services under this section, the
231.30 provider entity must directly provide the services; or if services are subcontracted, the
231.31 provider entity must maintain responsibility for services and billing.

232.1 ~~(b) A mobile crisis provider must meet the following standards:~~

232.2 ~~(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are~~
232.3 ~~available to a recipient 24 hours a day, seven days a week;~~

232.4 ~~(2) be able to respond to a call for services in a designated service area or according to~~
232.5 ~~a written agreement with the local mental health authority for an adjacent area;~~

232.6 ~~(3) have at least one mental health professional on staff at all times and at least one~~
232.7 ~~additional staff member capable of leading a crisis response in the community; and~~

232.8 ~~(4) provide the commissioner with information about the number of requests for service,~~
232.9 ~~the number of people that the provider serves face-to-face, outcomes, and the protocols that~~
232.10 ~~the provider uses when deciding when to respond in the community.~~

232.11 ~~(c) A provider entity that provides crisis stabilization services in a residential setting~~
232.12 ~~under subdivision 7 is not required to meet the requirements of paragraphs (a) and (b), but~~
232.13 ~~must meet all other requirements of this subdivision.~~

232.14 ~~(d) A crisis services provider must have the capacity to meet and carry out the standards~~
232.15 ~~in section 245L.011, subdivision 5, and the following standards:~~

232.16 ~~(1) ensures that staff persons provide support for a recipient's family and natural supports,~~
232.17 ~~by enabling the recipient's family and natural supports to observe and participate in the~~
232.18 ~~recipient's treatment, assessments, and planning services;~~

232.19 ~~(2) has adequate administrative ability to ensure availability of services;~~

232.20 ~~(3) is able to ensure that staff providing these services are skilled in the delivery of~~
232.21 ~~mental health crisis response services to recipients;~~

232.22 ~~(4) is able to ensure that staff are implementing culturally specific treatment identified~~
232.23 ~~in the crisis treatment plan that is meaningful and appropriate as determined by the recipient's~~
232.24 ~~culture, beliefs, values, and language;~~

232.25 ~~(5) is able to ensure enough flexibility to respond to the changing intervention and care~~
232.26 ~~needs of a recipient as identified by the recipient or family member during the service~~
232.27 ~~partnership between the recipient and providers;~~

232.28 ~~(6) is able to ensure that staff have the communication tools and procedures to~~
232.29 ~~communicate and consult promptly about crisis assessment and interventions as services~~
232.30 ~~occur;~~

233.1 ~~(7) is able to coordinate these services with county emergency services, community~~
 233.2 ~~hospitals, ambulance, transportation services, social services, law enforcement, engagement~~
 233.3 ~~services, and mental health crisis services through regularly scheduled interagency meetings;~~

233.4 ~~(8) is able to ensure that services are coordinated with other behavioral health service~~
 233.5 ~~providers, county mental health authorities, or federally recognized American Indian~~
 233.6 ~~authorities and others as necessary, with the consent of the recipient or parent or guardian.~~
 233.7 ~~Services must also be coordinated with the recipient's case manager if the recipient is~~
 233.8 ~~receiving case management services;~~

233.9 ~~(9) is able to ensure that crisis intervention services are provided in a manner consistent~~
 233.10 ~~with sections 245.461 to 245.486 and 245.487 to 245.489;~~

233.11 ~~(10) is able to coordinate detoxification services for the recipient according to Minnesota~~
 233.12 ~~Rules, parts 9530.6510 to 9530.6590, or withdrawal management according to chapter 245F;~~

233.13 ~~(11) is able to establish and maintain a quality assurance and evaluation plan to evaluate~~
 233.14 ~~the outcomes of services and recipient satisfaction; and~~

233.15 ~~(12) is an enrolled medical assistance provider.~~

233.16 (b) A mobile crisis provider must ensure services are provided consistent with section
 233.17 245.469, subdivisions 1 and 2.

233.18 Sec. 47. Minnesota Statutes 2024, section 256B.0624, is amended by adding a subdivision
 233.19 to read:

233.20 Subd. 7a. **Residential crisis stabilization services in adult foster care settings.** (a) If
 233.21 crisis stabilization services are provided in a supervised, licensed residential setting that
 233.22 serves no more than four adult residents, and one or more individuals are present at the
 233.23 setting to receive residential crisis stabilization, the residential setting staff must include,
 233.24 for at least eight hours per day, at least one mental health professional, clinical trainee,
 233.25 certified rehabilitation specialist, or mental health practitioner.

233.26 (b) The commissioner must establish a statewide per diem rate for crisis stabilization
 233.27 services provided under this paragraph to medical assistance enrollees. The rate for a provider
 233.28 must not exceed the rate charged by that provider for the same service to other payers.
 233.29 Payment must not be made to more than one entity for each individual for services provided
 233.30 under this paragraph on a given day. The commissioner must set rates prospectively for the
 233.31 annual rate period. The commissioner must require providers to submit annual cost reports
 233.32 on a uniform cost reporting form and use submitted cost reports to inform the rate-setting
 233.33 process. The commissioner must recalculate the statewide per diem every year.

234.1 (c) A provider under this subdivision must follow the requirements under section 245I.24,
234.2 subdivisions 4, paragraphs (c) and (d), and 9.

234.3 Sec. 48. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, as
234.4 amended by Laws 2026, chapter 95, article 5, section 27, is amended to read:

234.5 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
234.6 assistance covers services provided by a not-for-profit certified community behavioral health
234.7 clinic (CCBHC) that meets the requirements of section ~~245.735, subdivision 3~~ 245I.17.

234.8 (b) The commissioner must reimburse CCBHCs on a per-day basis for each day that an
234.9 eligible service is delivered using the CCBHC daily bundled rate system for medical
234.10 assistance payments as described in paragraph (c). The commissioner must include a quality
234.11 incentive payment in the CCBHC daily bundled rate system as described in paragraph (e).
234.12 There is no county share for medical assistance services when reimbursed through the
234.13 CCBHC daily bundled rate system.

234.14 (c) The commissioner must ensure that the CCBHC daily bundled rate system for CCBHC
234.15 payments under medical assistance meets the following requirements:

234.16 (1) the CCBHC daily bundled rate must be a provider-specific rate calculated for each
234.17 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable
234.18 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the
234.19 payment rate, total annual visits include visits covered by medical assistance and visits not
234.20 covered by medical assistance. Allowable costs include but are not limited to the salaries
234.21 and benefits of medical assistance providers; the cost of CCBHC services provided under
234.22 section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245I.17, subdivision 4;
234.23 and other costs such as insurance or supplies needed to provide CCBHC services;

234.24 (2) payment must be limited to one payment per day per medical assistance enrollee
234.25 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement
234.26 if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph~~
234.27 ~~(a), clause (6)~~ 245I.17, subdivision 4, is furnished to a medical assistance enrollee by a
234.28 health care practitioner or licensed agency employed by or under contract with a CCBHC;

234.29 (3) initial CCBHC daily bundled rates for newly ~~certified~~ licensed CCBHCs under
234.30 section ~~245.735, subdivision 3~~, 245I.17 must be established by the commissioner using a
234.31 provider-specific rate based on the newly ~~certified~~ licensed CCBHC's audited historical
234.32 cost report data adjusted for the expected cost of delivering CCBHC services. Estimates

235.1 are subject to review by the commissioner and must include the expected cost of providing
235.2 the full scope of CCBHC services and the expected number of visits for the rate period;

235.3 (4) the commissioner must rebase CCBHC rates once every two years following the last
235.4 rebasing and no less than 12 months following an initial rate or a rate change due to a change
235.5 in the scope of services;

235.6 (5) the commissioner must provide for a 60-day appeals process after notice of the results
235.7 of the rebasing;

235.8 (6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal
235.9 Medicaid rate is not eligible for the CCBHC rate methodology;

235.10 (7) payments for CCBHC services to individuals enrolled in managed care must be
235.11 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner must
235.12 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
235.13 of the CCBHC daily bundled rate system in the Medicaid Management Information System
235.14 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
235.15 due made payable to CCBHCs no later than 18 months thereafter;

235.16 (8) the CCBHC daily bundled rate for each CCBHC must be updated by trending each
235.17 provider-specific rate by the Medicare Economic Index for primary care services. This
235.18 update must occur each year in between rebasing periods determined by the commissioner
235.19 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
235.20 annually using the CCBHC cost report established by the commissioner; and

235.21 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
235.22 services when such changes are expected to result in an adjustment to the CCBHC payment
235.23 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information
235.24 regarding the changes in the scope of services, including the estimated cost of providing
235.25 the new or modified services and any projected increase or decrease in the number of visits
235.26 resulting from the change. Estimated costs are subject to review by the commissioner. Rate
235.27 adjustments for changes in scope must occur no more than once per year in between rebasing
235.28 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

235.29 (d) Managed care plans and county-based purchasing plans must reimburse CCBHC
235.30 providers at the CCBHC daily bundled rate. The commissioner must monitor the effect of
235.31 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
235.32 any contract year, federal approval is not received for this paragraph, the commissioner
235.33 must adjust the capitation rates paid to managed care plans and county-based purchasing
235.34 plans for that contract year to reflect the removal of this provision. Contracts between

236.1 managed care plans and county-based purchasing plans and providers to whom this paragraph
236.2 applies must allow recovery of payments from those providers if capitation rates are adjusted
236.3 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
236.4 to any increase in rates that results from this provision. This paragraph expires if federal
236.5 approval is not received for this paragraph at any time.

236.6 (e) The commissioner must implement a quality incentive payment program for CCBHCs
236.7 that meets the following requirements:

236.8 (1) a CCBHC must receive a quality incentive payment upon meeting specific numeric
236.9 thresholds for performance metrics established by the commissioner, in addition to payments
236.10 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in
236.11 paragraph (c);

236.12 (2) a CCBHC must be ~~certified~~ licensed and enrolled as a CCBHC for the entire
236.13 measurement year to be eligible for incentive payments;

236.14 (3) each CCBHC must receive written notice of the criteria that must be met in order to
236.15 receive quality incentive payments at least 90 days prior to the measurement year; and

236.16 (4) a CCBHC must provide the commissioner with data needed to determine incentive
236.17 payment eligibility within six months following the measurement year. The commissioner
236.18 must notify CCBHC providers of their performance on the required measures and the
236.19 incentive payment amount within 12 months following the measurement year.

236.20 (f) All claims to managed care plans for CCBHC services as provided under this section
236.21 must be submitted directly to, and paid by, the commissioner on the dates specified no later
236.22 than January 1 of the following calendar year, if:

236.23 (1) one or more managed care plans does not comply with the federal requirement for
236.24 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
236.25 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
236.26 days of noncompliance; and

236.27 (2) the total amount of clean claims not paid in accordance with federal requirements
236.28 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
236.29 eligible for payment by managed care plans.

236.30 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
236.31 year, claims must be submitted to and paid by the commissioner beginning on January 1 of
236.32 the following year. If the conditions in this paragraph are met between July 1 and December

237.1 31 of a calendar year, claims must be submitted to and paid by the commissioner beginning
237.2 on July 1 of the following year.

237.3 (g) Peer services provided by a CCBHC ~~certified~~ licensed under section ~~245.735~~ 245I.17
237.4 are a covered service under medical assistance when a licensed mental health professional
237.5 or alcohol and drug counselor determines that peer services are medically necessary.
237.6 Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility
237.7 standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph
237.8 (b), clause (2).

237.9 Sec. 49. Minnesota Statutes 2024, section 256B.0943, subdivision 2, is amended to read:

237.10 Subd. 2. **Covered service components of children's therapeutic services and**
237.11 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
237.12 children's therapeutic services and supports when the services are provided by an eligible
237.13 provider entity ~~certified under and meeting the standards in this section~~ licensed under
237.14 section 245I.30 or children's day treatment services licensed under section 245I.31. The
237.15 provider entity must make reasonable and good faith efforts to report individual client
237.16 outcomes to the commissioner, using instruments and protocols approved by the
237.17 commissioner.

237.18 (b) The covered service components of children's therapeutic services and supports are:

237.19 ~~(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,~~
237.20 ~~and group psychotherapy;~~

237.21 ~~(2) individual, family, or group skills training provided by a mental health professional,~~
237.22 ~~clinical trainee, or mental health practitioner;~~

237.23 ~~(3) crisis planning;~~

237.24 ~~(4) mental health behavioral aide services;~~

237.25 (1) the services described in section 245I.30, subdivision 2, provided by providers
237.26 licensed under section 245I.30 or 245I.31;

237.27 (2) administration of standardized measures;

237.28 ~~(5)~~ (3) direction of a mental health behavioral aide; and

237.29 ~~(6)~~ (4) mental health service plan development; and

237.30 ~~(7) children's day treatment.~~

(c) In delivering services under this section, a licensed provider entity must ensure that psychotherapy to address a child's underlying mental health disorder is documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive the psychotherapy or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record.

(d) Medical assistance covers service plan development before completion of a child's individual treatment plan. Service plan development consists of development, review, and revision of the individual treatment plan by face-to-face or electronic communication, including time spent gathering client history from other key figures or providers. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Service plan development is covered only if a treatment plan is completed or for work already completed at the time the client voluntarily chooses to disengage with services for the child. If it is determined upon review that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

(e) Medical assistance covers time spent administering and reporting standardized measures approved by the commissioner.

Sec. 50. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. Determination of client eligibility. (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a clinical trainee that is performed within one year before the initial start of service and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

~~(1) determine whether a child under age 18 has a diagnosis of mental illness or, if the person is between the ages of 18 and 21, whether the person has a mental illness; and~~

(2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; ~~and,~~

~~(3) be used in the development of the individual treatment plan.~~

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

~~(c) Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.~~

Sec. 51. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** (a) The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time, unless one service is delivered to the child and the other service is delivered to the child's family or treatment team without the child present;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

240.1 (ii) a social or educational service that does not have or cannot reasonably be expected
240.2 to have a therapeutic outcome related to the client's mental illness;

240.3 (iii) prevention or education programs provided to the community; and

240.4 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

240.5 (b) Time spent on administrative tasks before and after providing direct services, including
240.6 scheduling or maintaining clinical records, is included in CTSS payments and may not be
240.7 separately billed as additional clock hours of service.

240.8 Sec. 52. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended
240.9 to read:

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

240.16 (b) The Department of Human Services is the agency responsible for screening and
240.17 investigating allegations of maltreatment in juvenile correctional facilities listed under
240.18 section 241.021 located in the local welfare agency's county and in facilities licensed or
240.19 certified under chapters 245A and 245D.

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

240.23 (d) The Department of Education is the agency responsible for screening and investigating
240.24 allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11,
240.25 and 13, and chapter 124E. The Department of Education's responsibility to screen and
240.26 investigate includes allegations of maltreatment involving students 18 through 21 years of
240.27 age, including students receiving special education services, up to and including graduation
240.28 and the issuance of a secondary or high school diploma.

240.29 (e) The Department of Human Services is the agency responsible for screening and
240.30 investigating allegations of maltreatment of minors in an EIDBI agency operating under
240.31 sections 245A.142 and 256B.0949.

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

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

241.6 (h) The Department of Human Services is the agency responsible for screening and
241.7 investigating allegations of maltreatment of minors for mobile crisis response services and
241.8 children's therapeutic services and supports programs licensed under chapter 245I.

241.9 Sec. 53. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, as
241.10 amended by Laws 2026, chapter 95, article 7, section 25, is amended to read:

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

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

241.21 (b) The Department of Human Services is the lead investigative agency for facilities or
241.22 services licensed or required to be licensed as adult day care, adult foster care, community
241.23 residential settings, programs for people with disabilities, EIDBI agencies, family adult day
241.24 services, mental health programs licensed under chapter 245I, mental health clinics, substance
241.25 use disorder programs, the Minnesota Sex Offender Program, or any other facility or service
241.26 not listed in this subdivision that is licensed or required to be licensed by the Department
241.27 of Human Services. The Department of Human Services is also the lead investigative agency
241.28 for unlicensed EIDBI agencies under section 256B.0949. The Department of Human Services
241.29 is the lead investigative agency for adult rehabilitative mental health services under section
241.30 245I.22, mobile crisis response services under section 245I.24, and certified community
241.31 behavioral health clinics under section 245I.17.

241.32 (c) The county social services agency adult protective services or the agency's designee
241.33 or a federally recognized Indian Tribe that entered into a contractual agreement with the

242.1 commissioner of human services to operate adult protective services is the lead investigative
242.2 agency for all other reports, including but not limited to reports involving vulnerable adults
242.3 receiving services from a personal care provider organization under section 256B.0659 or
242.4 256B.85.

242.5 Sec. 54. **REVISOR INSTRUCTION.**

242.6 The revisor of statutes shall renumber Minnesota Statutes, section 245.735, subdivisions
242.7 5 and 6, as Minnesota Statutes, section 245I.17, subdivisions 23 and 24.

242.8 Sec. 55. **REPEALER.**

242.9 (a) Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e,
242.10 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, and 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23,
242.11 subdivision 23; 256B.0623, subdivisions 2, 4, 5, 6, and 9; 256B.0624, subdivisions 2, 3,
242.12 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11; and 256B.0943, subdivisions 4, 5, 5a, 6, 7, and 11, are
242.13 repealed.

242.14 (b) Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3 and 4d; and
242.15 256B.0943, subdivisions 1 and 9, are repealed.

242.16 Sec. 56. **EFFECTIVE DATE.**

242.17 This article is effective January 1, 2028.

242.18 **ARTICLE 8**

242.19 **UNIFORM SERVICE STANDARDS CONFORMING CHANGES**

242.20 Section 1. Minnesota Statutes 2024, section 13.46, subdivision 7, is amended to read:

242.21 Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and
242.22 shall not be disclosed, except:

242.23 (1) pursuant to section 13.05, as determined by the responsible authority for the
242.24 community mental health center, mental health division, or provider;

242.25 (2) pursuant to court order;

242.26 (3) pursuant to a statute specifically authorizing access to or disclosure of mental health
242.27 data or as otherwise provided by this subdivision;

243.1 (4) to personnel of the welfare system working in the same program or providing services
243.2 to the same individual or family to the extent necessary to coordinate services, provided
243.3 that a health record may be disclosed only as provided under section 144.293;

243.4 (5) to a health care provider governed by sections 144.291 to 144.298, to the extent
243.5 necessary to coordinate services; or

243.6 (6) with the consent of the client or patient.

243.7 (b) An agency of the welfare system may not require an individual to consent to the
243.8 release of mental health data as a condition for receiving services or for reimbursing a
243.9 community mental health center, mental health division of a county, or provider under
243.10 contract to deliver mental health services.

243.11 (c) Notwithstanding any other law to the contrary, a community mental health center,
243.12 mental health division of a county, or a mental health provider must disclose mental health
243.13 data to a law enforcement agency if the law enforcement agency provides the name of a
243.14 client or patient and communicates that the:

243.15 (1) client or patient is currently involved in a mental health crisis as defined in section
243.16 ~~256B.0624, subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the
243.17 law enforcement agency has responded; and

243.18 (2) data is necessary to protect the health or safety of the client or patient or of another
243.19 person.

243.20 The scope of disclosure under this paragraph is limited to the minimum necessary for
243.21 law enforcement to safely respond to the mental health crisis. Disclosure under this paragraph
243.22 may include the name and telephone number of the psychiatrist, psychologist, therapist,
243.23 mental health professional, practitioner, or case manager of the client or patient, if known;
243.24 and strategies to address the mental health crisis. A law enforcement agency that obtains
243.25 mental health data under this paragraph shall maintain a record of the requestor, the provider
243.26 of the data, and the client or patient name. Mental health data obtained by a law enforcement
243.27 agency under this paragraph are private data on individuals and must not be used by the
243.28 law enforcement agency for any other purpose. A law enforcement agency that obtains
243.29 mental health data under this paragraph shall inform the subject of the data that mental
243.30 health data was obtained.

243.31 (d) In the event of a request under paragraph (a), clause (6), a community mental health
243.32 center, county mental health division, or provider must release mental health data to Criminal

244.1 Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal
244.2 Mental Health Court personnel communicate that the:

244.3 (1) client or patient is a defendant in a criminal case pending in the district court;

244.4 (2) data being requested is limited to information that is necessary to assess whether the
244.5 defendant is eligible for participation in the Criminal Mental Health Court; and

244.6 (3) client or patient has consented to the release of the mental health data and a copy of
244.7 the consent will be provided to the community mental health center, county mental health
244.8 division, or provider within 72 hours of the release of the data.

244.9 For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty
244.10 criminal calendar of the Hennepin County District Court for defendants with mental illness
244.11 and brain injury where a primary goal of the calendar is to assess the treatment needs of the
244.12 defendants and to incorporate those treatment needs into voluntary case disposition plans.
244.13 The data released pursuant to this paragraph may be used for the sole purpose of determining
244.14 whether the person is eligible for participation in mental health court. This paragraph does
244.15 not in any way limit or otherwise extend the rights of the court to obtain the release of mental
244.16 health data pursuant to court order or any other means allowed by law.

244.17 Sec. 2. Minnesota Statutes 2024, section 144.294, subdivision 2, is amended to read:

244.18 Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293,
244.19 subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental
244.20 health to a law enforcement agency if the law enforcement agency provides the name of
244.21 the patient and communicates that the:

244.22 (1) patient is currently involved in a mental health crisis as defined in section ~~256B.0624,~~
244.23 ~~subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the law
244.24 enforcement agency has responded; and

244.25 (2) disclosure of the records is necessary to protect the health or safety of the patient or
244.26 of another person.

244.27 The scope of disclosure under this subdivision is limited to the minimum necessary for
244.28 law enforcement to safely respond to the mental health crisis. The disclosure may include
244.29 the name and telephone number of the psychiatrist, psychologist, therapist, mental health
244.30 professional, practitioner, or case manager of the patient, if known; and strategies to address
244.31 the mental health crisis. A law enforcement agency that obtains health records under this
244.32 subdivision shall maintain a record of the requestor, the provider of the information, and
244.33 the patient's name. Health records obtained by a law enforcement agency under this

245.1 subdivision are private data on individuals as defined in section 13.02, subdivision 12, and
245.2 must not be used by law enforcement for any other purpose. A law enforcement agency that
245.3 obtains health records under this subdivision shall inform the patient that health records
245.4 were obtained.

245.5 Sec. 3. Minnesota Statutes 2025 Supplement, section 245.4835, subdivision 2, is amended
245.6 to read:

245.7 Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with
245.8 subdivision 1, the commissioner shall require the county to develop a corrective action plan
245.9 according to a format and timeline established by the commissioner. If the commissioner
245.10 determines that a county has not developed an acceptable corrective action plan within the
245.11 required timeline, or that the county is not in compliance with an approved corrective action
245.12 plan, the protections provided to that county under section 245.485 do not apply.

245.13 (b) The commissioner shall consider the following factors to determine whether to
245.14 approve a county's corrective action plan:

245.15 (1) the degree to which a county is maximizing revenues for mental health services from
245.16 noncounty sources;

245.17 (2) the degree to which a county is expanding use of alternative services that meet mental
245.18 health needs, but do not count as mental health services within existing reporting systems.
245.19 If approved by the commissioner, the alternative services must be included in the county's
245.20 base as well as subsequent years. The commissioner's approval for alternative services must
245.21 be based on the following criteria:

245.22 (i) the service must be provided to children or adults with mental illness;

245.23 (ii) the services must be based on an individual treatment plan or individual community
245.24 support plan as defined in the Comprehensive Mental Health Act; and

245.25 (iii) the services must be supervised by a mental health professional and provided by
245.26 staff who meet the staff qualifications defined in sections ~~256B.0943, subdivision 7~~ 245I.30,
245.27 subdivision 4, and ~~256B.0623, subdivision 5~~ 245I.22, subdivision 5.

245.28 (c) Additional county expenditures to make up for the prior year's underspending may
245.29 be spread out over a two-year period.

246.1 Sec. 4. Minnesota Statutes 2025 Supplement, section 245.4871, subdivision 4, is amended
246.2 to read:

246.3 Subd. 4. **Case management service provider.** (a) "Case management service provider"
246.4 means a case manager or case manager associate employed by the county or other entity
246.5 authorized by the county board to provide case management services specified in subdivision
246.6 3 for the child with serious mental illness and the child's family.

246.7 (b) A case manager must:

246.8 (1) have experience and training in working with children;

246.9 (2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least
246.10 a bachelor's degree in one of the behavioral sciences or a related field including, but not
246.11 limited to, social work, psychology, or nursing from an accredited college or university or
246.12 meet the requirements of paragraph (d);

246.13 (3) have experience and training in identifying and assessing a wide range of children's
246.14 needs;

246.15 (4) be knowledgeable about local community resources and how to use those resources
246.16 for the benefit of children and their families; and

246.17 (5) meet the supervision and continuing education requirements of paragraphs (e), (f),
246.18 and (g), as applicable.

246.19 (c) A case manager may be a member of any professional discipline that is part of the
246.20 local system of care for children established by the county board.

246.21 (d) A case manager who is not a mental health practitioner and does not have a bachelor's
246.22 degree or who has a bachelor's degree that is not in one of the behavioral sciences or related
246.23 fields must meet one of the requirements in clauses (1) to (5):

246.24 (1) have three or four years of experience as a case manager associate;

246.25 (2) be a registered nurse without a bachelor's degree who has a combination of specialized
246.26 training in psychiatry and work experience consisting of community interaction and
246.27 involvement or community discharge planning in a mental health setting totaling three years;

246.28 (3) be a person who qualified as a case manager under the 1998 Department of Human
246.29 Services waiver provision and meets the continuing education, supervision, and mentoring
246.30 requirements in this section;

247.1 (4) prior to direct service delivery, complete at least 80 hours of specific training on the
247.2 characteristics and needs of children with serious mental illness that is consistent with
247.3 national practices standards; or

247.4 (5) prior to direct service delivery, demonstrate competency in practice and knowledge
247.5 of the characteristics and needs of children with serious mental illness, consistent with
247.6 national practices standards.

247.7 (e) A case manager with at least 2,000 hours of supervised experience in the delivery
247.8 of mental health services to children must receive regular ongoing supervision and clinical
247.9 supervision totaling 38 hours per year, of which at least one hour per month must be clinical
247.10 supervision regarding individual service delivery with a case management supervisor. The
247.11 other 26 hours of supervision may be provided by a case manager with two years of
247.12 experience. Group supervision may not constitute more than one-half of the required
247.13 supervision hours.

247.14 (f) A case manager without 2,000 hours of supervised experience in the delivery of
247.15 mental health services to children with mental illness must:

247.16 (1) begin 40 hours of training approved by the commissioner of human services in case
247.17 management skills and in the characteristics and needs of children with serious mental
247.18 illness before beginning to provide case management services; and

247.19 (2) receive clinical supervision regarding individual service delivery from a mental
247.20 health professional at least one hour each week until the requirement of 2,000 hours of
247.21 experience is met.

247.22 (g) A case manager who is not licensed, registered, or certified by a health-related
247.23 licensing board must receive 30 hours of continuing education and training in serious mental
247.24 illness and mental health services every two years.

247.25 (h) Clinical supervision must be documented in the child's record. When the case manager
247.26 is not a mental health professional, the county board must provide or contract for needed
247.27 clinical supervision.

247.28 (i) The county board must ensure that the case manager has the freedom to access and
247.29 coordinate the services within the local system of care that are needed by the child.

247.30 (j) A case manager associate (CMA) must:

247.31 (1) work under the direction of a case manager or case management supervisor;

247.32 (2) be at least 21 years of age;

248.1 (3) have at least a high school diploma or its equivalent; and

248.2 (4) meet one of the following criteria:

248.3 (i) have an associate of arts degree in one of the behavioral sciences or human services;

248.4 (ii) be a registered nurse without a bachelor's degree;

248.5 (iii) have three years of life experience as a primary caregiver to a child with serious

248.6 mental illness as defined in subdivision 6 within the previous ten years;

248.7 (iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

248.8 (v) have 6,000 hours of supervised work experience in the delivery of mental health

248.9 services to children with mental illness; hours worked as a mental health behavioral aide I

248.10 or II under section ~~256B.0943, subdivision 7~~ 245I.30, subdivision 4,, may count toward the

248.11 6,000 hours of supervised work experience.

248.12 Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager

248.13 after four years of supervised work experience as a case manager associate. Individuals

248.14 meeting the criteria in item (v) may qualify as a case manager after three years of supervised

248.15 experience as a case manager associate.

248.16 (k) Case manager associates must meet the following supervision, mentoring, and

248.17 continuing education requirements:

248.18 (1) have 40 hours of preservice training described under paragraph (f), clause (1);

248.19 (2) receive at least 40 hours of continuing education in serious mental illness and mental

248.20 health service annually; and

248.21 (3) receive at least five hours of mentoring per week from a case management mentor.

248.22 A "case management mentor" means a qualified, practicing case manager or case management

248.23 supervisor who teaches or advises and provides intensive training and clinical supervision

248.24 to one or more case manager associates. Mentoring may occur while providing direct services

248.25 to consumers in the office or in the field and may be provided to individuals or groups of

248.26 case manager associates. At least two mentoring hours per week must be individual and

248.27 face-to-face.

248.28 (l) A case management supervisor must meet the criteria for a mental health professional

248.29 as specified in subdivision 27.

248.30 (m) An immigrant who does not have the qualifications specified in this subdivision

248.31 may provide case management services to child immigrants with serious mental illness of

248.32 the same ethnic group as the immigrant if the person:

249.1 (1) is currently enrolled in and is actively pursuing credits toward the completion of a
249.2 bachelor's degree in one of the behavioral sciences or related fields at an accredited college
249.3 or university;

249.4 (2) completes 40 hours of training as specified in this subdivision; and

249.5 (3) receives clinical supervision at least once a week until the requirements of obtaining
249.6 a bachelor's degree and 2,000 hours of supervised experience are met.

249.7 Sec. 5. Minnesota Statutes 2024, section 245.4882, subdivision 6, is amended to read:

249.8 Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential
249.9 treatment services under this section for the purpose of crisis stabilization by:

249.10 (1) a mental health professional as defined in section 245I.04, subdivision 2;

249.11 (2) a physician licensed under chapter 147 who is assessing a child in an emergency
249.12 department; or

249.13 (3) a member of a mobile crisis team who meets the qualifications under section
249.14 ~~256B.0624, subdivision 5~~ 245I.24, subdivision 5.

249.15 (b) A provider making a referral under paragraph (a) must conduct an assessment of the
249.16 child's mental health needs and make a determination that the child is experiencing a mental
249.17 health crisis and is in need of residential treatment services under this section.

249.18 (c) A child may receive services under this subdivision for up to 30 days and must be
249.19 subject to the screening and admissions criteria and processes under section 245.4885
249.20 thereafter.

249.21 Sec. 6. Minnesota Statutes 2025 Supplement, section 245.735, subdivision 4d, is amended
249.22 to read:

249.23 Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment
249.24 plan must be completed within 60 calendar days following the preliminary screening and
249.25 risk assessment and updated no less frequently than every six months or when the client's
249.26 circumstances change.

249.27 (b) Only a mental health professional may complete an integrated treatment plan. The
249.28 mental health professional must consult with an alcohol and drug counselor when substance
249.29 use disorder services are deemed clinically appropriate. An alcohol and drug counselor may
249.30 approve the integrated treatment plan. The integrated treatment plan must be developed

250.1 through a shared decision-making process with the client, the client's support system if the
250.2 client chooses, or, for children, with the family or caregivers.

250.3 (c) The integrated treatment plan must:

250.4 (1) use the ASAM 6 dimensional framework; and

250.5 (2) incorporate prevention, medical and behavioral health needs, and service delivery.

250.6 (d) The psychiatric evaluation and management service fulfills requirements for the
250.7 integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric
250.8 evaluation and management services. The CCBHC must complete an integrated treatment
250.9 plan within 60 calendar days of a client's referral for additional CCBHC services.

250.10 (e) Notwithstanding any law to the contrary, an integrated treatment plan developed by
250.11 a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

250.12 (1) section 245G.06, subdivision 1;

250.13 (2) section 245G.09, subdivision 3, paragraph (a), clause (6); and

250.14 (3) section 245I.10, subdivisions 7 and 8; and.

250.15 ~~(4) section 256B.0943, subdivision 6, paragraph (b), clause (2).~~

250.16 Sec. 7. Minnesota Statutes 2024, section 245A.26, subdivision 3, is amended to read:

250.17 Subd. 3. **Eligibility for services.** An individual is eligible for children's residential crisis
250.18 stabilization services if the individual is under 21 years of age and meets the eligibility
250.19 criteria for crisis services under section ~~256B.0624, subdivision 3~~ 245I.24, subdivision 3.

250.20 Sec. 8. Minnesota Statutes 2024, section 245A.26, subdivision 4, is amended to read:

250.21 Subd. 4. **Required services; providers.** (a) A license holder providing residential crisis
250.22 stabilization services must continually follow a client's individual crisis treatment plan to
250.23 improve the client's functioning.

250.24 (b) The license holder must offer and have the capacity to directly provide the following
250.25 treatment services to a client:

250.26 (1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ 245I.24,
250.27 subdivision 9;

250.28 (2) mental health services as specified in the client's individual crisis treatment plan,
250.29 according to the client's treatment needs;

(3) health services and medication administration, if applicable; and

(4) referrals for the client to community-based treatment providers and support services for the client's transition from residential crisis stabilization to another treatment setting.

(c) Children's residential crisis stabilization services must be provided by a qualified staff person listed in section ~~256B.0624, subdivision 8~~ 245I.24, subdivision 9, paragraph (b), according to the scope of practice for the individual staff person's position.

Sec. 9. Minnesota Statutes 2024, section 245A.26, subdivision 5, is amended to read:

Subd. 5. Assessment and treatment planning. (a) Within 12 hours of a client's admission for residential crisis stabilization, the license holder must assess the client and document the client's immediate needs, including the client's:

(1) health and safety, including the need for crisis assistance;

(2) need for connection to family and other natural supports;

(3) if applicable, housing and legal issues; and

(4) if applicable, responsibilities for children, family, and other natural supports, and employers.

(b) Within 24 hours of a client's admission for residential crisis stabilization, the license holder must complete a crisis treatment plan for the client, according to the requirements for a crisis treatment plan under section ~~256B.0624, subdivision 11~~ 245I.24, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and the assessment of the client's immediate needs under paragraph (a). A mental health professional or a clinical trainee under the supervision of a mental health professional must complete the crisis treatment plan. A crisis treatment plan completed by a clinical trainee must contain documentation of approval, as defined in section 245I.02, subdivision 2, by a mental health professional within five business days of initial completion by the clinical trainee.

(c) A mental health professional must review a client's crisis treatment plan each week and document the weekly reviews in the client's client file.

(d) For a client receiving children's residential crisis stabilization services who is 18 years of age or older, the license holder must complete an individual abuse prevention plan for the client, pursuant to section 245A.65, subdivision 2, as part of the client's crisis treatment plan.

252.1 Sec. 10. Minnesota Statutes 2024, section 245C.10, subdivision 8, is amended to read:

252.2 Subd. 8. **Children's therapeutic services and supports providers.** The commissioner
252.3 shall recover the cost of background studies required under section 245C.03, subdivision
252.4 7, for the purposes of children's therapeutic services and supports under section ~~256B.0943~~
252.5 245I.30, through a fee of no more than \$44 per study charged to the license holder. The fees
252.6 collected under this subdivision are appropriated to the commissioner for the purpose of
252.7 conducting background studies.

252.8 Sec. 11. Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

252.9 Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the
252.10 license holder must follow a client's individual crisis treatment plan to provide services to
252.11 the client in residential crisis stabilization to improve the client's functioning.

252.12 (b) The license holder must offer and have the capacity to directly provide the following
252.13 treatment services to the client:

252.14 (1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ 245I.24,
252.15 subdivision 9;

252.16 (2) rehabilitative mental health services;

252.17 (3) health services and administering the client's medications; and

252.18 (4) making referrals for the client to other service providers in the community and
252.19 supporting the client's transition from residential crisis stabilization to another setting.

252.20 Sec. 12. Minnesota Statutes 2024, section 245I.23, subdivision 8, is amended to read:

252.21 Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a)
252.22 Within 12 hours of a client's admission, the license holder must evaluate the client and
252.23 document the client's immediate needs, including the client's:

252.24 (1) health and safety, including the client's need for crisis assistance;

252.25 (2) responsibilities for children, family and other natural supports, and employers; and

252.26 (3) housing and legal issues.

252.27 (b) Within 24 hours of a client's admission, the license holder must complete a crisis
252.28 treatment plan for the client under section ~~256B.0624, subdivision 11~~ 245I.24, subdivision
252.29 11. The license holder must base the client's crisis treatment plan on the client's referral
252.30 information and an assessment of the client's immediate needs.

253.1 (c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete
253.2 an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

253.3 Sec. 13. Minnesota Statutes 2024, section 245I.23, subdivision 16, is amended to read:

253.4 Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client
253.5 for residential crisis stabilization is an individual who is age 18 or older and meets the
253.6 eligibility criteria in section ~~256B.0624, subdivision 3~~ 245I.24, subdivision 3.

253.7 Sec. 14. Minnesota Statutes 2024, section 256B.092, subdivision 14, is amended to read:

253.8 Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions,**
253.9 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons
253.10 receiving home and community-based services authorized under this section who have had
253.11 two or more admissions within a calendar year to an emergency room, psychiatric unit, or
253.12 institution must receive consultation from a mental health professional as defined in section
253.13 245.462, subdivision 18, or a behavioral professional as defined in the home and
253.14 community-based services state plan within 30 days of discharge. The mental health
253.15 professional or behavioral professional must:

253.16 (1) conduct a functional assessment of the crisis incident as defined in section 245D.02,
253.17 subdivision 11, which led to the hospitalization with the goal of developing proactive
253.18 strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable
253.19 hospitalizations due to a behavioral crisis;

253.20 (2) use the results of the functional assessment to amend the support plan set forth in
253.21 section 245D.02, subdivision 4b, to address the potential need for additional staff training,
253.22 increased staffing, access to crisis mobility services, mental health services, use of
253.23 technology, and crisis stabilization services in section ~~256B.0624, subdivision 7~~ 245I.24,
253.24 subdivision 9; and

253.25 (3) identify the need for additional consultation, testing, and mental health crisis
253.26 intervention team services as defined in section 245D.02, subdivision 20, psychotropic
253.27 medication use and monitoring under section 245D.051, and the frequency and duration of
253.28 ongoing consultation.

253.29 (b) For the purposes of this subdivision, "institution" includes, but is not limited to, the
253.30 Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

254.1 Sec. 15. Minnesota Statutes 2024, section 256B.49, subdivision 25, is amended to read:

254.2 Subd. 25. **Reduce avoidable behavioral crisis emergency room admissions,**
254.3 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons
254.4 receiving home and community-based services authorized under this section who have two
254.5 or more admissions within a calendar year to an emergency room, psychiatric unit, or
254.6 institution must receive consultation from a mental health professional as defined in section
254.7 245.462, subdivision 18, or a behavioral professional as defined in the home and
254.8 community-based services state plan within 30 days of discharge. The mental health
254.9 professional or behavioral professional must:

254.10 (1) conduct a functional assessment of the crisis incident as defined in section 245D.02,
254.11 subdivision 11, which led to the hospitalization with the goal of developing proactive
254.12 strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable
254.13 hospitalizations due to a behavioral crisis;

254.14 (2) use the results of the functional assessment to amend the support plan in section
254.15 245D.02, subdivision 4b, to address the potential need for additional staff training, increased
254.16 staffing, access to crisis mobility services, mental health services, use of technology, and
254.17 crisis stabilization services in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9; and

254.18 (3) identify the need for additional consultation, testing, mental health crisis intervention
254.19 team services as defined in section 245D.02, subdivision 20, psychotropic medication use
254.20 and monitoring under section 245D.051, and the frequency and duration of ongoing
254.21 consultation.

254.22 (b) For the purposes of this subdivision, "institution" includes, but is not limited to, the
254.23 Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

254.24 Sec. 16. Minnesota Statutes 2025 Supplement, section 256L.03, subdivision 5, as amended
254.25 by Laws 2026, chapter 95, article 5, section 38, is amended to read:

254.26 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to
254.27 children under the age of 21 and to American Indians as defined in Code of Federal
254.28 Regulations, title 42, section 600.5.

254.29 (b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered
254.30 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
254.31 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
254.32 services exempt from cost-sharing under state law. The cost-sharing changes described in
254.33 this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention, crisis stabilization provided in a community setting, or crisis assessment as defined in section ~~256B.0624, subdivision 2~~ 245I.24, subdivision 2.

Sec. 17. **EFFECTIVE DATE.**

This article is effective January 1, 2028.

ARTICLE 9

AGING AND DISABILITY SERVICES

Section 1. Minnesota Statutes 2025 Supplement, section 144.0724, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. Minnesota Statutes 2024, section 245A.04, subdivision 2, is amended to read:

Subd. 2. **Notification of affected municipality.** The commissioner must not issue a license under this chapter without giving 30 calendar days' written notice to the affected

257.1 municipality or other political subdivision unless the program is considered a permitted
257.2 single-family residential use under sections 245A.11 and 245A.14. If the program is
257.3 considered a permitted single-family residence, the commissioner must give the affected
257.4 municipality or other political subdivision written notice of the issuance no later than five
257.5 days after issuing the license, excluding weekends and holidays. The written notice must
257.6 include the prospective license holder's name and contact information, the license type and
257.7 capacity, and the proposed address of the licensed facility or program. The commissioner
257.8 may provide notice through electronic communication. The notification must be given
257.9 before the first issuance of a license under this chapter and annually after that time if annual
257.10 notification is requested in writing by the affected municipality or other political subdivision.
257.11 State funds must not be made available to or be spent by an agency or department of state,
257.12 county, or municipal government for payment to a residential or nonresidential program
257.13 licensed under this chapter until the provisions of this subdivision have been complied with
257.14 in full. The provisions of this subdivision shall not apply to programs located in hospitals.

257.15 **EFFECTIVE DATE.** This section is effective July 1, 2026, and applies to licenses
257.16 issued on or after that date.

257.17 Sec. 3. Minnesota Statutes 2024, section 245A.04, subdivision 2a, is amended to read:

257.18 Subd. 2a. **Meeting fire and safety codes.** (a) An applicant or license holder under
257.19 sections 245A.01 to 245A.16 must document compliance with applicable building codes,
257.20 fire and safety codes, health rules, and zoning ordinances, or document that an appropriate
257.21 waiver has been granted.

257.22 (b) At the request of a county or local unit of government, the commissioner may delegate
257.23 to a county agency or local unit of government the commissioner's or local agency's authority
257.24 to inspect an existing residential program serving six or fewer persons for compliance with
257.25 zoning ordinances and applicable physical plant licensing requirements. If the commissioner
257.26 delegates the commissioner's or local agency's authority to a county agency or local unit of
257.27 government under this subdivision, the commissioner must execute a formal delegation of
257.28 authority that clearly specifies what authority is being delegated to the county agency or
257.29 local unit of government, that the commissioner is responsible for any costs incurred by the
257.30 county agency or local unit of government for conducting inspections under delegated
257.31 authority, and that the county agency or local unit of government must not assess any
257.32 additional fees for conducting an inspection under delegated authority. When conducting
257.33 an inspection under delegated authority, the county agency or local unit of government must
257.34 provide the subject of the inspection with a copy of the delegation of authority.

(c) When a county agency or local unit of government is conducting an inspection under delegated authority as provided in paragraph (b), the county agency or local unit of government and the agency responsible for licensing inspections must coordinate inspections to minimize visits to and disruptions of the residential program. A county agency or local unit of government conducting an inspection must notify the commissioner of any violations or concerns within ten days of the inspection, excluding weekends and holidays. A county agency or local unit of government that conducts inspections under this subdivision must not inspect a residential program more frequently than annually, except a follow-up inspection is permitted before the next annual inspection to verify correction of a violation discovered during the most recent inspection.

(d) The commissioner must ensure that laws, rules, and codes are uniformly enforced throughout the state by reviewing at least every four years each county agency and local unit of government conducting inspections under this subdivision for compliance with this subdivision and other applicable laws and rules.

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

Sec. 4. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision to read:

Subd. 7. **Colocation of certain home and community-based residential settings.** (a) Effective July 1, 2026, the commissioner must not authorize services in or issue an initial license under this chapter or chapter 245D for any of the following residential settings or programs unless the proposed setting meets the heightened home and community-based setting standards described in this subdivision:

(1) a community residential setting, as defined in section 245D.02, subdivision 4a;

(2) an adult foster care home;

(3) a setting providing customized living services with a resident capacity of six or fewer;

(4) a setting providing 24-hour customized living services with a resident capacity of six or fewer; and

(5) an assisted living facility licensed under chapter 144G with a resident capacity of six or fewer.

(b) Newly licensed settings enumerated in paragraph (a) must not be located on the same property or on an adjoining property of any existing community residential setting, any existing adult foster care setting, any existing setting providing family residential services

259.1 to an adult, any existing setting providing customized living services with a resident capacity
259.2 of six or fewer, any existing setting providing 24-hour customized living services with a
259.3 resident capacity of six or fewer, or any existing assisted living facility licensed under
259.4 chapter 144G with a resident capacity of six or fewer. The requirements of this paragraph
259.5 apply regardless of who owns or controls the existing setting. The commissioner must
259.6 comply with section 245A.11, subdivision 4, when authorizing services or issuing an initial
259.7 license under this subdivision.

259.8 (c) For the purposes of this subdivision, "adjoining property" means a property that
259.9 shares a common boundary line with another property. Adjoining property also includes
259.10 properties that meet at a common corner point. The presence of a right-of-way or public
259.11 easement, including but not limited to a bicycle path, alley, or residential street, between
259.12 adjoining properties, including between properties that but for the right-of-way or public
259.13 easement would share a common corner point, are adjoining properties.

259.14 Sec. 5. Minnesota Statutes 2024, section 245D.12, is amended to read:

259.15 **245D.12 INTEGRATED COMMUNITY SUPPORTS; ~~SETTING CAPACITY~~**
259.16 **REPORT.**

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

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

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

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

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

259.31 (4) the total number of people who could reside in the living units in the multifamily
259.32 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. Licensure moratorium. (a) Except as permitted in this subdivision, the commissioner must not issue an initial license under this chapter authorizing integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and must not approve a license change adding integrated community supports to an existing license under this chapter.

(b) The commissioner may approve an exception to the moratorium only when the applicant or licensee meets all requirements under subdivision 1, the request is not superseded by temporary moratoriums under section 245A.03, subdivision 7a, and the applicant submits documentation demonstrating compliance with:

(1) federal and state home and community-based services requirements for provider-controlled settings;

(2) the prohibition on the use of Medicaid money for room and board under United States Code, title 42, section 1396n(c); and

(3) all licensing requirements applicable to integrated community supports under this chapter.

(c) In determining whether to approve an exception, the commissioner must consider statewide and regional capacity for integrated community supports based on needs determination processes under section 245A.03, subdivision 7, paragraph (e).

(d) A determination under this subdivision is final and not subject to appeal.

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

Sec. 6. Minnesota Statutes 2024, section 256.01, subdivision 21, is amended to read:

Subd. 21. **Interagency ~~agreement~~ agreements with Department of Health.** (a) The commissioner of human services shall amend the interagency agreement with the commissioner of health to certify nursing facilities for participation in the medical assistance program, to require the commissioner of health, as a condition of the agreement, to comply beginning July 1, 2005, with action plans included in the annual survey and certification quality improvement report required under section 144A.10, subdivision 17.

261.1 (b) The commissioners of health and human services must execute an interagency
261.2 agreement to determine on behalf of the commissioner of health whether an assisted living
261.3 facility for which either an applicant is seeking a provisional license under chapter 144G
261.4 or a licensee is seeking to relocate under section 144G.195 meets the standards described
261.5 in section 245A.042, subdivision 7.

261.6 Sec. 7. Minnesota Statutes 2025 Supplement, section 256.4792, subdivision 1, is amended
261.7 to read:

261.8 Subdivision 1. **Long-term services and supports loan program.** The commissioner
261.9 of human services shall establish a loan program to provide operating loans to eligible
261.10 long-term services and supports providers. ~~The commissioner shall initiate the application~~
261.11 ~~process for the loan described in this section on an ongoing basis.~~ The commissioner must
261.12 not issue any new loans under this program after June 30, 2026.

261.13 Sec. 8. Minnesota Statutes 2025 Supplement, section 256.4792, subdivision 7, is amended
261.14 to read:

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

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

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

261.29 (1) the amount of the delinquent contractual payment;

261.30 (2) the amount of the withholding per payment period;

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

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

262.3 (5) other contents as the commissioner deems appropriate.

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

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

262.11 (f) By January 15 each year, the commissioner must provide to the chairs and ranking
262.12 minority members of the legislative committees with jurisdiction over nursing facilities a
262.13 report of all facilities that are delinquent in their repayments. The reporting required under
262.14 this paragraph expires upon notification by the commissioner to the committees that there
262.15 are no outstanding balances from loan awards issued under this subdivision.

262.16 Sec. 9. Minnesota Statutes 2025 Supplement, section 256.4792, is amended by adding a
262.17 subdivision to read:

262.18 Subd. 11. **Loan program expiration.** This section expires after the commissioner collects
262.19 all loan repayments incurred on or before June 30, 2026. The commissioner must notify the
262.20 revisor of statutes once all loan repayments under this section are collected.

262.21 Sec. 10. Minnesota Statutes 2024, section 256.975, subdivision 7b, is amended to read:

262.22 Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal
262.23 screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

262.24 (1) a person who, having entered an acute care facility from a certified nursing facility,
262.25 is returning to a certified nursing facility; or

262.26 (2) a person transferring from one certified nursing facility in Minnesota to another
262.27 certified nursing facility in Minnesota.

262.28 (b) Persons who are exempt from preadmission screening for purposes of level of care
262.29 determination include:

262.30 (1) persons described in paragraph (a);

263.1 (2) an individual who has a contractual right to have nursing facility care paid for
263.2 indefinitely by the Veterans Administration; and

263.3 (3) an individual enrolled in a demonstration project under section 256B.69, subdivision
263.4 8, at the time of application to a nursing facility; and

263.5 ~~(4) an individual currently being served under the alternative care program or under a~~
263.6 ~~home and community-based services waiver authorized under section 1915(e) of the federal~~
263.7 ~~Social Security Act.~~

263.8 (c) Persons admitted to a Medicaid-certified nursing facility from the community on an
263.9 emergency basis as described in paragraph (d) or from an acute care facility on a nonworking
263.10 day must be screened the first working day after admission.

263.11 (d) Emergency admission to a nursing facility prior to screening is permitted when all
263.12 of the following conditions are met:

263.13 (1) a person is admitted from the community to a certified nursing or certified boarding
263.14 care facility during Senior LinkAge Line nonworking hours;

263.15 (2) a physician, advanced practice registered nurse, or physician assistant has determined
263.16 that delaying admission until preadmission screening is completed would adversely affect
263.17 the person's health and safety;

263.18 (3) there is a recent precipitating event that precludes the client from living safely in the
263.19 community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's
263.20 inability to continue to provide care;

263.21 (4) the attending physician, advanced practice registered nurse, or physician assistant
263.22 has authorized the emergency placement and has documented the reason that the emergency
263.23 placement is recommended; and

263.24 (5) the Senior LinkAge Line is contacted on the first working day following the
263.25 emergency admission.

263.26 (e) Transfer of a patient from an acute care hospital to a nursing facility is not considered
263.27 an emergency except for a person who has received hospital services in the following
263.28 situations: hospital admission for observation, care in an emergency room without hospital
263.29 admission, or following hospital 24-hour bed care and from whom admission is being sought
263.30 on a nonworking day.

263.31 (f) A nursing facility must provide written information to all persons admitted regarding
263.32 the person's right to request and receive long-term care consultation services as defined in

264.1 section 256B.0911, subdivision 11. The information must be provided prior to the person's
264.2 discharge from the facility and in a format specified by the commissioner.

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

264.4 Sec. 11. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision
264.5 to read:

264.6 Subd. 28. **Interpretive guidelines for disability waiver regulation.** (a) The
264.7 commissioner must develop and publish interpretive guidelines within 120 calendar days
264.8 of the effective date of any statutory changes, waiver plan amendments, state or federal
264.9 administrative rulings, or state or federal court decisions that affect policies or reimbursement
264.10 for services licensed under chapter 245D, authorized under section 256B.092 or 256B.49,
264.11 or reimbursed under section 256B.4914.

264.12 (b) Interpretive guidelines issued by the commissioner under this subdivision do not
264.13 have the force and effect of law and have no precedential effect but may be relied on by
264.14 consumers, providers of service, county agencies, the Department of Human Services, and
264.15 others concerned until revoked or modified. An interpretive guideline may be expressly
264.16 revoked or modified by the commissioner or by the issuance of another interpretive guideline
264.17 but may not be revoked or modified retroactively to the detriment of consumers, providers
264.18 of service, county agencies, the Department of Human Services, or others concerned. A
264.19 change in the law or an interpretation of the law occurring after the interpretive guidelines
264.20 are issued, whether in the form of a statute, court decision, administrative ruling, or
264.21 subsequent interpretive guideline, results in the revocation or modification of the previously
264.22 adopted guidelines to the extent that the change affects the guidelines.

264.23 **EFFECTIVE DATE.** This section is effective July 1, 2028, and applies to statutory
264.24 changes, waiver plan amendments, state or federal administrative rulings, or state or federal
264.25 court decisions effective or issued on or after that date.

264.26 Sec. 12. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision
264.27 to read:

264.28 Subd. 29. **Certified assessor team.** The commissioner must employ certified assessors
264.29 within the department to conduct assessments under section 256B.0911 on behalf of lead
264.30 agencies under conditions and circumstances determined by the commissioner. Certified
264.31 assessors employed by the commissioner may conduct assessments in addition to other
264.32 duties as assigned, except the certified assessors employed by the commissioner must not
264.33 perform any responsibilities of a lead agency described in section 256B.0911 other than

265.1 assessments. Nothing in this subdivision creates an obligation for the commissioner to
265.2 provide the department's certified assessors to conduct assessments on behalf of a lead
265.3 agency.

265.4 **EFFECTIVE DATE.** This section is effective July 1, 2027.

265.5 Sec. 13. Minnesota Statutes 2024, section 256B.0659, subdivision 12, is amended to read:

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

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

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

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

265.17 (2) provider name and telephone numbers;

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

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

265.22 (5) signatures of recipient or the responsible party;

265.23 (6) personal signature of the personal care assistant;

265.24 (7) any shared ~~care~~ services provided, if applicable;

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

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

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

266.1 Sec. 14. Minnesota Statutes 2024, section 256B.0659, subdivision 16, is amended to read:

266.2 Subd. 16. **Shared services.** (a) Medical assistance payments for ~~shared~~ personal care
266.3 assistance services that are shared services are limited according to this subdivision.

266.4 (b) ~~Shared service is~~ For the purposes of this section, "shared services" means the
266.5 provision of personal care assistance services by a personal care assistant to two or three
266.6 recipients, who are all eligible for medical assistance, and who each voluntarily enter into
266.7 an agreement to receive services at the same time and in the same setting.

266.8 (c) For the purposes of this subdivision, "setting" means:

266.9 (1) the home residence or family foster care home of one or more of the individual
266.10 recipients; or

266.11 (2) a child care program licensed under chapter 142B or operated by a local school
266.12 district or private school.

266.13 (d) ~~Shared personal care assistance~~ services follow the same criteria for covered services
266.14 as subdivision 2.

266.15 (e) ~~Noncovered shared personal care assistance~~ services include the following:

266.16 (1) services for more than three recipients by one personal care assistant at one time;

266.17 (2) staff requirements for child care programs under chapter 245C;

266.18 (3) caring for multiple recipients in more than one setting;

266.19 (4) additional units of personal care assistance based on the selection of the option; and

266.20 (5) use of more than one personal care assistance provider agency for the ~~shared care~~
266.21 services.

266.22 (f) The option of ~~shared personal care assistance~~ services is elected by the recipient or
266.23 the responsible party with the assistance of the assessor. The option must be determined
266.24 appropriate based on the ages of the recipients, compatibility, and coordination of their
266.25 assessed care needs. The recipient or the responsible party, in conjunction with the qualified
266.26 professional, shall arrange the setting and grouping of shared services based on the individual
266.27 needs and preferences of the recipients. The personal care assistance provider agency shall
266.28 offer the recipient or the responsible party the option of shared services or one-on-one
266.29 personal care assistance services or a combination of both. The recipient or the responsible
266.30 party may withdraw from participating in a shared services arrangement at any time.

267.1 (g) Authorization for the shared service option must be determined by the commissioner
267.2 based on the criteria that the shared service is appropriate to meet all of the recipients' needs
267.3 and ~~their~~ the recipients' health and safety is maintained. The authorization of shared services
267.4 is part of the overall authorization of personal care assistance services. Nothing in this
267.5 subdivision must be construed to reduce the total number of hours authorized for an individual
267.6 recipient.

267.7 (h) A personal care assistant providing shared ~~personal care assistance~~ services must:

267.8 (1) receive training specific for each recipient served; and

267.9 (2) follow all required documentation requirements for time and services provided.

267.10 (i) A qualified professional shall:

267.11 (1) evaluate the ability of the personal care assistant to provide services ~~for all of~~ to all
267.12 the recipients in a shared setting;

267.13 (2) visit the shared setting as shared services are being provided at least once every six
267.14 months or whenever needed for response to a recipient's request for increased supervision
267.15 of the personal care assistance staff;

267.16 (3) provide ongoing monitoring and evaluation of the effectiveness and appropriateness
267.17 of the shared services;

267.18 (4) develop a contingency plan with each of the recipients ~~which~~ that accounts for absence
267.19 of the recipient in a shared services setting due to illness or other circumstances;

267.20 (5) obtain permission from each of the recipients who are sharing a personal care assistant
267.21 for number of shared hours for services provided inside and outside the home residence;
267.22 and

267.23 (6) document the training completed by the personal care assistants specific to the shared
267.24 setting and recipients sharing services.

267.25 Sec. 15. Minnesota Statutes 2024, section 256B.0659, subdivision 17, is amended to read:

267.26 Subd. 17. **Shared services; rates.** (a) For the purposes of this subdivision, "additional
267.27 revenue for shared services" means the difference between the rate paid to a personal care
267.28 assistance provider agency for serving a single recipient and the sum of the rates paid to a
267.29 personal care assistance provider agency for shared services provided to more than one
267.30 recipient.

(b) For the purposes of this subdivision, "wages and wage-related costs" means increased wages and any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation premiums, and contributions to employee retirement accounts if the contribution is a function of wages.

(c) The commissioner shall provide a rate system for shared ~~personal care assistance~~ services. For two ~~persons~~ recipients sharing services, the rate paid to a personal care assistance provider agency for the shared services must not exceed one and one-half times the rate paid for serving a single ~~individual~~, and recipient. For three ~~persons~~ recipients sharing services, the rate paid to a personal care assistance provider agency for the shared services must not exceed twice the rate paid for serving a single ~~individual~~ recipient. These rates apply only when all of the criteria for the shared ~~care~~ ~~personal care assistance service~~ have been services are met.

(d) Of the additional revenue for shared services provided to two recipients, the personal care assistance provider agency must use 90 percent for the purposes specified in paragraph (e). Of the additional revenue for shared services provided to three recipients, the personal care assistance provider agency must use 90 percent for the purposes specified in paragraph (e).

(e) A personal care assistance provider agency must use the percentages of additional revenue for shared services specified in paragraph (d) for the wages and wage-related costs of the personal care assistant providing the shared services. The personal care assistance provider agency must not use additional revenue for shared services to pay for mileage reimbursements, uniform allowances, health and dental insurance, life insurance, disability insurance, long-term care insurance, contributions to employee retirement accounts if the contribution is not a function of wages, or any other employee benefits.

Sec. 16. Minnesota Statutes 2024, section 256B.0659, subdivision 19, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

270.14 Sec. 17. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 30, is
270.15 amended to read:

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

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

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

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

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

- 271.1 (5) information about Minnesota health care programs;
- 271.2 (6) the person's freedom to accept or reject the recommendations of the team;
- 271.3 (7) the person's right to confidentiality under the Minnesota Government Data Practices
- 271.4 Act, chapter 13;
- 271.5 (8) the certified assessor's decision regarding the person's need for institutional level of
- 271.6 care as determined under criteria established in subdivision 26 and regarding eligibility for
- 271.7 all services and programs as defined in subdivision 11, clauses (7) to (10);
- 271.8 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
- 271.9 all services and programs as defined in subdivision 11, clauses (5), (7) to (10), and (15),
- 271.10 and the decision regarding the need for institutional level of care, ~~an attestation to no changes~~
- 271.11 ~~in needs or services~~, or the lead agency's final decisions regarding public programs eligibility
- 271.12 according to section 256.045, subdivision 3. The certified assessor must verbally
- 271.13 communicate this appeal right to the person and must visually point out where in the
- 271.14 document the right to appeal is stated; and
- 271.15 (10) documentation that available options for employment services, independent living,
- 271.16 and self-directed services and supports were described to the person.

271.17 Sec. 18. Minnesota Statutes 2024, section 256B.0911, subdivision 32, as amended by

271.18 Laws 2026, chapter 95, article 4, section 17, is amended to read:

271.19 Subd. 32. **Administrative activity.** (a) The commissioner shall:

271.20 (1) streamline the processes, including timelines for when assessments need to be

271.21 completed;

271.22 (2) provide the services in this section; ~~and~~

271.23 (3) implement integrated solutions to automate the business processes to the extent

271.24 necessary for support plan approval, reimbursement, program planning, evaluation, and

271.25 policy development; and

271.26 (4) effective July 1, 2028, grant limited role-based access to a person's support plan in

271.27 the MnCHOICES system to home and community-based service providers who have been

271.28 designated as a provider for that person by a lead agency for the purpose of signing the

271.29 person's support plan electronically and demonstrating that the provider has reviewed,

271.30 understood, and agrees to deliver services as outlined in the plan.

271.31 (b) The commissioner shall work with lead agencies responsible for conducting long-term

271.32 care consultation services to modify the MnCHOICES application and assessment policies

272.1 to create efficiencies while ensuring federal compliance with medical assistance and
272.2 long-term services and supports eligibility criteria.

272.3 Sec. 19. Minnesota Statutes 2024, section 256B.0922, is amended by adding a subdivision
272.4 to read:

272.5 Subd. 3. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval, whichever
272.6 is later, billable unit maximums are established for the following services authorized under
272.7 this section:

272.8 (1) for chore services, a maximum of 24 units per week per recipient, where a unit is
272.9 defined as a 15-minute increment;

272.10 (2) for homemaker services, cleaning and home management may be provided for a
272.11 maximum of 16 hours combined per week per recipient; and

272.12 (3) for personal emergency response system services, a maximum of one unit per month
272.13 per recipient.

272.14 (b) Billing limits under this subdivision apply only to the individual service listed and
272.15 do not prohibit the recipient from accessing other services for which they are eligible on
272.16 the same day, week, or month, subject to other applicable requirements.

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

272.18 Sec. 20. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision
272.19 to read:

272.20 Subd. 20. **Billing limits.** (a) Effective July 1, 2027, or upon federal approval, whichever
272.21 is later, the following billing limits apply to early intensive developmental and behavioral
272.22 intervention services:

272.23 (1) intensive services: 40 hours per week per recipient;

272.24 (2) travel: two hours per day per recipient;

272.25 (3) observation and direction: 20 hours per week per recipient; and

272.26 (4) individual treatment and planning: 300 units per year per recipient.

272.27 (b) The commissioner must grant exceptions to the billing limits under paragraph (a)
272.28 when services in excess of the billing limits are determined to be medically necessary. A
272.29 provider must apply to the commissioner for an exception on the forms and in the manner

273.1 prescribed by the commissioner. A determination under this paragraph is final and not
273.2 subject to appeal.

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

273.4 Sec. 21. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision
273.5 to read:

273.6 Subd. 17. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval,
273.7 whichever is later, billable unit maximums are established for the following services
273.8 authorized under sections 256B.092 and 256B.49:

273.9 (1) for assistive technology authorized under section 256B.092, a maximum of \$10,000
273.10 annually per recipient;

273.11 (2) for chore services, a maximum of 24 units per week per recipient, where a unit is
273.12 defined as a 15-minute increment;

273.13 (3) for homemaker services, cleaning and home management may be provided for a
273.14 maximum of 16 hours combined per week per recipient;

273.15 (4) for family training and counseling, a maximum of two hours per week per recipient;

273.16 (5) for independent living skills, a maximum of six hours per day per recipient; and

273.17 (6) for personal emergency response system services, a maximum of one unit per month
273.18 per recipient.

273.19 (b) The limits in this subdivision do not limit a person's use of other waiver services.

273.20 Billing limits under this subdivision apply only to the individual service listed and do not
273.21 prohibit the recipient from accessing other services for which they are eligible on the same
273.22 day, week, or month, subject to other applicable requirements.

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

273.24 Sec. 22. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision
273.25 to read:

273.26 Subd. 18. **Prohibition on room and board payments.** (a) The provider must not use
273.27 medical assistance money to pay for room and board, including but not limited to rent,
273.28 mortgage payments, utilities, property taxes, homeowners association fees, or any other
273.29 housing-related cost, in accordance with federal home and community-based services waiver
273.30 requirements under United States Code, title 42, section 1396n(c), and Code of Federal
273.31 Regulations, title 42, section 441.310.

274.1 (b) A provider of home and community-based services, including but not limited to
274.2 integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause
274.3 (8), must not:

274.4 (1) use, allocate, or apply any payment for home and community-based services to cover,
274.5 subsidize, discount, or otherwise contribute to any room and board expenses for a person
274.6 receiving services;

274.7 (2) apply agency operating margins, reserves, or profits derived from home and
274.8 community-based services to pay for rent or pay other housing costs for persons receiving
274.9 services; or

274.10 (3) enter into any financial arrangement, discount, concession, or reimbursement structure
274.11 that has the effect of using medical assistance service revenue to offset the housing costs
274.12 of a person receiving services.

274.13 (c) Nothing in this subdivision prohibits a provider from charging a person for room
274.14 and board in accordance with chapter 504B or applicable housing support laws, provided
274.15 the charge is independent of medical assistance payments and complies with all federal
274.16 home and community-based services setting requirements, including but not limited to
274.17 tenancy protections under Code of Federal Regulations, title 42, section 441.301(c)(4)(vi)(A).

274.18 (d) The commissioner may pursue corrective action, payment recovery, sanctions under
274.19 section 256B.064, and licensing action under chapter 245A or 245D for a violation of this
274.20 subdivision.

274.21 (e) Notwithstanding paragraphs (a) and (b), payment for room and board is permitted
274.22 when explicitly included as part of a service authorized in a federally approved home and
274.23 community-based services waiver under United States Code, title 42, section 1396n(c).

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

274.25 Sec. 23. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 3, is
274.26 amended to read:

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

274.31 (1) 24-hour customized living;

274.32 (2) adult day services;

- 275.1 (3) adult day services bath;
- 275.2 (4) community residential services;
- 275.3 (5) customized living;
- 275.4 (6) day support services;
- 275.5 (7) employment development services;
- 275.6 (8) employment exploration services;
- 275.7 (9) employment support services;
- 275.8 (10) family residential services;
- 275.9 (11) individualized home supports;
- 275.10 (12) individualized home supports with family training;
- 275.11 (13) individualized home supports with training;
- 275.12 (14) integrated community supports;
- 275.13 (15) life sharing;
- 275.14 (16) effective until the effective date of clauses (17) and (18), night supervision;
- 275.15 (17) effective January 1, 2026, or upon federal approval, whichever is later, awake night
- 275.16 supervision;
- 275.17 (18) effective January 1, 2026, or upon federal approval, whichever is later, asleep night
- 275.18 supervision;
- 275.19 (19) positive support services;
- 275.20 (20) prevocational services;
- 275.21 (21) residential support services;
- 275.22 (22) transportation services;
- 275.23 (23) effective October 1, 2027, or upon federal approval, whichever is later, integrated
- 275.24 community supports access services; and
- 275.25 ~~(23)~~ (24) other services as approved by the federal government in the state home and
- 275.26 community-based services waiver plan.

276.1 Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 5a, is
276.2 amended to read:

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

276.5 (1) for supervisory staff, 100 percent of the median wage for community and social
276.6 services specialist (SOC code 21-1099), with the exception of the supervisor of positive
276.7 supports professional, positive supports analyst, and positive supports specialist, which is
276.8 100 percent of the median wage for clinical counseling and school psychologist (SOC code
276.9 19-3031);

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

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

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

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

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

276.21 (ii) 85 percent of the subtotal of 40 percent of the median wage for home health and
276.22 personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant
276.23 (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code
276.24 29-2053); and 20 percent of the median wage for social and human services aide (SOC code
276.25 21-1093);

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

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

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

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

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

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

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

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

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

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

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

277.28 (17) effective until the effective date of clauses (18) and (19), for night supervision staff,
277.29 40 percent of the median wage for home health and personal care aide (SOC code 31-1120);
277.30 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the
277.31 median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median
277.32 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 of 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; and

(20) effective October 1, 2027, or upon federal approval, whichever is later, for integrated community support 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).

Sec. 25. Minnesota Statutes 2024, section 256B.4914, subdivision 6, is amended to read:

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

(b) Effective October 1, 2027, or upon federal approval, whichever is later, for purposes of this section, residential support services includes 24-hour customized living services, community residential services, customized living services, and integrated community supports access services.

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

279.1 ~~(e)~~ (d) When the available shared staffing hours in a residential setting are insufficient
279.2 to meet the needs of an individual who enrolled in residential support services after January
279.3 1, 2014, then individual staffing hours shall be used.

279.4 Sec. 26. Minnesota Statutes 2024, section 256B.4914, subdivision 6a, is amended to read:

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

279.7 (1) competitive workforce factor: 6.7 percent;

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

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

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

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

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

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

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

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

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

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

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

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

279.27 (6) multiply the number of shared direct staffing and individual direct staffing hours
279.28 provided on site or through monitoring technology and nursing hours by the product of the
279.29 supervision span of control ratio and the appropriate supervisory staff wage in subdivision
279.30 5a, clause (1);

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

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

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

280.10 (10) for transportation, if provided, add \$1,742.62 divided by 365, or \$3,111.81 divided
280.11 by 365 if customized for adapted transport, based on the resident with the highest assessed
280.12 need. The commissioner shall update the amounts in this clause as specified in subdivision
280.13 5b;

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

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

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

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

280.23 (c) Effective July 1, 2027, the commissioner must establish the following acuity-based
280.24 community residential service tool input limits on total individual hours entered, based on
280.25 the case mix rates determined under this section:

280.26 (1) zero individual hours per day for people assessed for case mixes A, C, and L;

280.27 (2) no more than six individual hours per day for people assessed for case mixes B, D,
280.28 and F;

280.29 (3) no more than 16 individual hours per day for people assessed for case mixes E, G,
280.30 I, J, and K; and

281.1 (4) no more than 24 individual hours per day for people assessed for case mix H or
281.2 residing in a community residential setting licensed for one person regardless of case mix
281.3 level.

281.4 (d) The commissioner must provide an exception process under subdivision 14 to the
281.5 limits in paragraph (c) for individuals with extraordinary needs who might otherwise end
281.6 up in institutional settings without additional authorized individual hour inputs.

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

281.8 Sec. 27. Minnesota Statutes 2024, section 256B.4914, subdivision 6c, is amended to read:

281.9 Subd. 6c. **Integrated community supports; component values and calculation of**
281.10 **payment rates.** (a) Component values for integrated community supports are:

281.11 (1) competitive workforce factor: 6.7 percent;

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

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

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

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

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

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

281.18 (b) Payments for integrated community supports must be calculated as follows:

281.19 (1) determine the number of shared direct staffing and individual direct staffing hours
281.20 to meet a recipient's needs. The base shared direct staffing hours must be eight hours divided
281.21 by the ~~number of people receiving support in approved capacity of the integrated community~~
281.22 support setting, and the individual direct staffing hours must be the average number of direct
281.23 support hours provided directly to the service recipient;

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

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

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

282.1 (5) multiply the number of shared direct staffing and individual direct staffing hours in
282.2 clause (1) by the appropriate staff wages;

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

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

282.9 (8) for employee-related expenses, multiply the direct staffing cost by one plus the
282.10 employee-related cost ratio;

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

282.13 (10) add the results of clauses (8) and (9);

282.14 (11) add the standard general administrative support ratio, the program-related expense
282.15 ratio, and the absence and utilization factor ratio;

282.16 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
282.17 total payment amount; and

282.18 (13) adjust the result of clause (12) by a factor to be determined by the commissioner
282.19 to adjust for regional differences in the cost of providing services.

282.20 (c) The commissioner must establish maximum allowable in-person and remote service
282.21 hours used in the rate methodology for integrated community supports based on the recipient's
282.22 case mix classification. Effective January 1, 2027, the total number of service hours entered
282.23 into the rate framework must not exceed the following limits:

282.24 (1) for case mix classifications A, C, and L, a maximum of two hours per day;

282.25 (2) for case mix classifications B, D, and F, a maximum of four hours per day;

282.26 (3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

282.27 (4) for case mix classification H, a maximum of eight hours per day.

282.28 (d) The daily limit in paragraph (c) does not limit a person's use of other disability waiver
282.29 services that may be provided on the same day in alignment with the federally approved
282.30 waiver. Nothing in paragraph (c) prohibits approval of a rate exception for individuals with
282.31 exceptional or complex needs.

283.1 (e) This subdivision expires upon the effective date of subdivisions 6e and 8a.

283.2 Sec. 28. Minnesota Statutes 2024, section 256B.4914, subdivision 6d, is amended to read:

283.3 Subd. 6d. **Payment for customized living.** (a) The payment methodology for customized
283.4 living and 24-hour customized living must be the customized living tool. The commissioner
283.5 shall revise the customized living tool to reflect the services and activities unique to
283.6 disability-related recipient needs and adjust for regional differences in the cost of providing
283.7 services.

283.8 (b) The rate adjustments described in section 256S.205 do not apply to rates paid under
283.9 this section.

283.10 (c) Customized living and 24-hour customized living rates determined under this section
283.11 shall not include more than 24 hours of support in a daily unit.

283.12 (d) The commissioner shall establish the following acuity-based customized living tool
283.13 input limits, based on case mix, for customized living and 24-hour customized living rates
283.14 determined under this section:

283.15 (1) no more than two hours of mental health management per day for people assessed
283.16 for case mixes A, D, and G;

283.17 (2) no more than four hours of activities of daily living assistance per day for people
283.18 assessed for case mix B; and

283.19 (3) no more than six hours of activities of daily living assistance per day for people
283.20 assessed for case mix D.

283.21 (e) Effective January 1, 2027, or upon federal approval, whichever is later, customized
283.22 living monthly service rate limits must equal the monthly service rate limits determined
283.23 under section 256S.202, subdivisions 1 and 2, multiplied by 126.36 percent.

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

283.25 Sec. 29. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
283.26 to read:

283.27 Subd. 6e. **Integrated community supports access services; component values and**
283.28 **calculation of payment rates.** (a) This subdivision is effective October 1, 2027, or upon
283.29 federal approval, whichever is later.

283.30 (b) Component values for integrated community supports access services are:

- 284.1 (1) competitive workforce factor: 6.7 percent;
- 284.2 (2) supervisory span of control ratio: 11 percent;
- 284.3 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 284.4 (4) employee-related cost ratio: 23.6 percent;
- 284.5 (5) general administrative support ratio: 13.25 percent;
- 284.6 (6) program-related expense ratio: 1.3 percent; and
- 284.7 (7) absence and utilization factor ratio: 3.9 percent.
- 284.8 (c) Payments for integrated community supports access services must be calculated as
- 284.9 follows:
- 284.10 (1) the base shared direct staffing hours must be eight hours divided by the approved
- 284.11 capacity of integrated community support setting;
- 284.12 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
- 284.13 provided in subdivisions 5 and 5a;
- 284.14 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
- 284.15 product of one plus the competitive workforce factor;
- 284.16 (4) for a recipient requiring customization for deaf and hard-of-hearing language
- 284.17 accessibility under subdivision 12, add the customization rate provided in subdivision 12
- 284.18 to the result of clause (3);
- 284.19 (5) multiply the number of shared direct staffing hours in clause (1) by the appropriate
- 284.20 staff wages;
- 284.21 (6) multiply the number of shared direct staffing hours in clause (1) by the product of
- 284.22 the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision
- 284.23 5a, clause (1);
- 284.24 (7) combine the results of clauses (5) and (6) and multiply the result by one plus the
- 284.25 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
- 284.26 cost;
- 284.27 (8) for employee-related expenses, multiply the direct staffing cost by one plus the
- 284.28 employee-related cost ratio;
- 284.29 (9) for client programming and supports, add \$2,260.21 divided by 365. The
- 284.30 commissioner shall update the amount in this clause as specified in subdivision 5b;

- 285.1 (10) add the results of clauses (8) and (9);
- 285.2 (11) add the standard general administrative support ratio, the program-related expense
- 285.3 ratio, and the absence and utilization factor ratio;
- 285.4 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
- 285.5 total payment amount; and
- 285.6 (13) adjust the result of clause (12) by a factor to be determined by the commissioner
- 285.7 to adjust for regional differences in the cost of providing residential services.
- 285.8 Sec. 30. Minnesota Statutes 2024, section 256B.4914, subdivision 7b, is amended to read:
- 285.9 Subd. 7b. **Day support services; component values and calculation of payment**
- 285.10 **rates.** (a) Component values for day support services are:
- 285.11 (1) competitive workforce factor: 6.7 percent;
- 285.12 (2) supervisory span of control ratio: 11 percent;
- 285.13 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 285.14 (4) employee-related cost ratio: 23.6 percent;
- 285.15 (5) program plan support ratio: 5.6 percent;
- 285.16 (6) client programming and support ratio: 10.37 percent, updated as specified in
- 285.17 subdivision 5b;
- 285.18 (7) general administrative support ratio: 13.25 percent;
- 285.19 (8) program-related expense ratio: 1.8 percent; and
- 285.20 (9) absence and utilization factor ratio: 9.4 percent.
- 285.21 (b) A unit of service for day support services is 15 minutes.
- 285.22 (c) Payments for day support services must be calculated as follows:
- 285.23 (1) determine the number of units of service and the staffing ratio to meet a recipient's
- 285.24 needs;
- 285.25 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
- 285.26 provided in subdivisions 5 and 5a;
- 285.27 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
- 285.28 product of one plus the competitive workforce factor;

- 286.1 (4) for a recipient requiring customization for deaf and hard-of-hearing language
286.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
286.3 to the result of clause (3);
- 286.4 (5) multiply the number of day program direct staffing hours and nursing hours by the
286.5 appropriate staff wage;
- 286.6 (6) multiply the number of day program direct staffing hours by the product of the
286.7 supervisory span of control ratio and the appropriate supervisory staff wage in subdivision
286.8 5a, clause (1);
- 286.9 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
286.10 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
286.11 rate;
- 286.12 (8) for program plan support, multiply the result of clause (7) by one plus the program
286.13 plan support ratio;
- 286.14 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
286.15 employee-related cost ratio;
- 286.16 (10) for client programming and supports, multiply the result of clause (9) by one plus
286.17 the client programming and support ratio;
- 286.18 (11) for program facility costs, add \$19.30 per week with consideration of staffing ratios
286.19 to meet individual needs, updated as specified in subdivision 5b;
- 286.20 (12) this is the subtotal rate;
- 286.21 (13) sum the standard general administrative rate support ratio, the program-related
286.22 expense ratio, and the absence and utilization factor ratio;
- 286.23 (14) divide the result of clause (12) by one minus the result of clause (13). This is the
286.24 total payment amount; and
- 286.25 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
286.26 to adjust for regional differences in the cost of providing services.
- 286.27 (d) Effective January 1, 2027, or upon federal approval, whichever is later, the billing
286.28 limit for day support services is equal to a maximum of eight hours per day per recipient.
- 286.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

287.1 Sec. 31. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 8, is
287.2 amended to read:

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

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

287.10 (1) competitive workforce factor: 6.7 percent;

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

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

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

287.14 (5) program plan support ratio: 15.5 percent;

287.15 (6) client programming and support ratio: 4.7 percent, updated as specified in subdivision
287.16 5b;

287.17 (7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

- 288.1 (4) for a recipient requiring customization for deaf and hard-of-hearing language
288.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
288.3 to the result of clause (3);
- 288.4 (5) multiply the number of direct staffing hours by the appropriate staff wage;
- 288.5 (6) multiply the number of direct staffing hours by the product of the supervisory span
288.6 of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);
- 288.7 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
288.8 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
288.9 rate;
- 288.10 (8) for program plan support, multiply the result of clause (7) by one plus the program
288.11 plan support ratio;
- 288.12 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
288.13 employee-related cost ratio;
- 288.14 (10) for client programming and supports, multiply the result of clause (9) by one plus
288.15 the client programming and support ratio;
- 288.16 (11) this is the subtotal rate;
- 288.17 (12) sum the standard general administrative support ratio, the program-related expense
288.18 ratio, and the absence and utilization factor ratio;
- 288.19 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
288.20 total payment amount;
- 288.21 (14) for services provided in a shared manner, divide the total payment in clause (13)
288.22 as follows:
- 288.23 (i) for employment exploration services, divide by the number of service recipients, not
288.24 to exceed five;
- 288.25 (ii) for employment support services, divide by the number of service recipients, not to
288.26 exceed six;
- 288.27 (iii) for individualized home supports with training and individualized home supports
288.28 with family training, divide by the number of service recipients, not to exceed three; and
- 288.29 (iv) for night supervision, divide by the number of service recipients, not to exceed two;
288.30 and

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

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

289.11 (f) Effective January 1, 2027, or upon federal approval, whichever is later, a provider
289.12 must not bill more than:

289.13 (1) for individualized home supports with training, a monthly service limit of 182.5
289.14 hours; and

289.15 (2) for individualized home supports with family training, not more than six total hours
289.16 per day.

289.17 (g) The limits in paragraph (f), clauses (1) and (2), do not limit a person's use of other
289.18 disability waiver services, including individualized home supports, which may be provided
289.19 on the same day by the same provider providing individualized home supports with training
289.20 or individualized home supports with family training.

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

289.22 Sec. 32. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
289.23 to read:

289.24 **Subd. 8a. Integrated community supports unit-based services with programming;**
289.25 **component values and calculation of payment rates.** (a) This subdivision is effective
289.26 October 1, 2027, or upon federal approval, whichever is later.

289.27 (b) Component values for integrated community supports unit-based services with
289.28 programming are:

289.29 (1) competitive workforce factor: 6.7 percent;

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

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

- 290.1 (4) employee-related cost ratio: 23.6 percent;
- 290.2 (5) program plan support ratio: 11.25 percent;
- 290.3 (6) client programming and support ratio: 3.5 percent, updated as specified in subdivision
- 290.4 5b;
- 290.5 (7) general administrative support ratio: 13.25 percent;
- 290.6 (8) program-related expense ratio: 1.3 percent; and
- 290.7 (9) absence and utilization factor ratio: 3.9 percent.
- 290.8 (c) A unit of integrated community supports unit-based services with programming is
- 290.9 15 minutes.
- 290.10 (d) Payments for integrated community supports unit-based services must be calculated
- 290.11 as follows:
- 290.12 (1) determine the number of units of service to meet a recipient's needs;
- 290.13 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
- 290.14 provided in subdivisions 5 to 5a;
- 290.15 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
- 290.16 product of one plus the competitive workforce factor;
- 290.17 (4) for a recipient requiring customization for deaf and hard-of-hearing language
- 290.18 accessibility under subdivision 12, add the customization rate provided in subdivision 12
- 290.19 to the result of clause (3);
- 290.20 (5) multiply the number of direct staffing hours by the appropriate staff wage;
- 290.21 (6) multiply the number of direct staffing hours by the product of the supervisory span
- 290.22 of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);
- 290.23 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
- 290.24 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
- 290.25 rate;
- 290.26 (8) for program plan support, multiply the result of clause (7) by one plus the program
- 290.27 plan support ratio;
- 290.28 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
- 290.29 employee-related cost ratio;

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

291.3 (11) this is the subtotal rate;

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

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

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

291.10 (e) The commissioner must establish maximum allowable in-person and remote service
291.11 hours used in the rate methodology for integrated community supports based on the recipient's
291.12 case mix classification. The total number of service hours entered into the rate framework
291.13 must not exceed the following limits:

291.14 (1) for case mix classifications A, C, and L, a maximum of two hours per day;

291.15 (2) for case mix classifications B, D, and F, a maximum of four hours per day;

291.16 (3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

291.17 (4) for case mix classification H, a maximum of eight hours per day.

291.18 (f) The daily limit in paragraph (e) does not limit a person's use of other disability waiver
291.19 services that may be provided on the same day in alignment with the federally approved
291.20 waiver. Nothing in paragraph (e) prohibits approval of a rate exception for individuals with
291.21 exceptional or complex needs.

291.22 Sec. 33. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 9, is
291.23 amended to read:

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

291.30 (b) Effective January 1, 2026, or upon federal approval, whichever is later, for the
291.31 purposes of this section, unit-based services without programming include individualized

292.1 home supports without training, awake night supervision, and asleep night supervision
292.2 provided to an individual outside of any service plan for a day program or residential support
292.3 service.

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

292.5 (1) competitive workforce factor: 6.7 percent;

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

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

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

292.9 (5) program plan support ratio: 7.0 percent;

292.10 (6) client programming and support ratio: 2.3 percent, updated as specified in subdivision
292.11 5b;

292.12 (7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

293.10 (11) this is the subtotal rate;

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

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

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

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

293.20 (f) Effective January 1, 2027, or upon federal approval, whichever is later, the billing
293.21 limit for awake night supervision and asleep night supervision is equal to a maximum of
293.22 ten hours per day per recipient, of which no more than eight hours per day may be asleep
293.23 night supervision.

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

293.25 Sec. 34. Minnesota Statutes 2024, section 256B.4914, subdivision 9a, is amended to read:

293.26 Subd. 9a. **Respite services; component values and calculation of payment rates.** (a)
293.27 For the purposes of this section, respite services include respite services provided to an
293.28 individual outside of any service plan for a day program or residential support service.

293.29 (b) Component values for respite services are:

293.30 (1) competitive workforce factor: 4.7 percent;

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

- 294.1 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 294.2 (4) employee-related cost ratio: 23.6 percent;
- 294.3 (5) general administrative support ratio: 13.25 percent;
- 294.4 (6) program-related expense ratio: 2.9 percent; and
- 294.5 (7) absence and utilization factor ratio: 3.9 percent.
- 294.6 (c) A unit of service for respite services is 15 minutes.
- 294.7 (d) Payments for respite services must be calculated as follows unless the service is
- 294.8 reimbursed separately as part of a residential support services or day program payment rate:
- 294.9 (1) determine the number of units of service to meet an individual's needs;
- 294.10 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
- 294.11 provided in subdivisions 5 and 5a;
- 294.12 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
- 294.13 product of one plus the competitive workforce factor;
- 294.14 (4) for a recipient requiring deaf and hard-of-hearing customization under subdivision
- 294.15 12, add the customization rate provided in subdivision 12 to the result of clause (3);
- 294.16 (5) multiply the number of direct staffing hours by the appropriate staff wage;
- 294.17 (6) multiply the number of direct staffing hours by the product of the supervisory span
- 294.18 of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);
- 294.19 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
- 294.20 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
- 294.21 rate;
- 294.22 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
- 294.23 employee-related cost ratio;
- 294.24 (9) this is the subtotal rate;
- 294.25 (10) sum the standard general administrative support ratio, the program-related expense
- 294.26 ratio, and the absence and utilization factor ratio;
- 294.27 (11) divide the result of clause (9) by one minus the result of clause (10). This is the
- 294.28 total payment amount;
- 294.29 (12) for respite services provided in a shared manner, divide the total payment amount
- 294.30 in clause (11) by the number of service recipients, not to exceed three; 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.

(e) Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for in-home respite services is equal to a maximum of 30 consecutive days per respite occurrence.

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

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

Subd. 10e. **Documentation of staffing; auditing and rate review.** (a) Effective for services provided on or after January 1, 2029, a provider enrolled to provide residential support services under subdivision 6 must maintain documentation of direct staffing hours provided to each person receiving services, including but not limited to documentation identifying:

(1) the name, role, and unique identifier for each staff person who provided services to match records to payroll, time and attendance systems, and any other source documentation;

(2) the date services were provided;

(3) the total number of hours of direct support provided;

(4) awake overnight staffing hours provided, if applicable;

(5) asleep overnight staffing hours provided, if applicable; and

(6) any other staffing information required by the commissioner.

(b) A provider must maintain documentation in a manner and format determined by the commissioner for at least six years. If a provider changes payroll vendors, merges operations, or changes staffing identifiers, the provider must maintain a documented link between prior and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and role classification for each staff person.

(c) A provider must submit the documentation required under paragraph (a) to the commissioner annually, in a manner and format determined by the commissioner. The commissioner must establish multiple submission windows throughout the calendar year and may assign providers to a submission window for administrative efficiency and system capacity. Documentation must reflect staffing provided during the prior calendar year and must be submitted no later than the final business day of the provider's assigned submission window. The commissioner may conduct random or targeted validations and audits of

296.1 submitted data and may require supplemental documentation as necessary to verify accuracy
296.2 and compliance.

296.3 (d) The commissioner must conduct periodic analysis of documentation submitted under
296.4 this subdivision and may validate staffing data through random audits or other verification
296.5 methods.

296.6 (e) Based on the analysis under paragraph (d), the commissioner may provide
296.7 recommendations to lead agencies regarding modifications to the rate of a person receiving
296.8 services, including increases or decreases necessary to align the rate with staffing provided
296.9 to the person as demonstrated by the submitted historical staffing documentation.
296.10 Recommendations must be based on the requirements of this section and applicable federal
296.11 and state requirements governing rate setting.

296.12 (f) If a provider fails to submit documentation requested within the submission window
296.13 in paragraph (c), the commissioner must issue a written notice of noncompliance. If
296.14 documentation is not received within 60 days following the notice of noncompliance, the
296.15 commissioner may temporarily suspend payments to the provider until the required
296.16 documentation is submitted. The commissioner must make withheld payments to the provider
296.17 once the required documentation is received. If the noncompliance persists, the commissioner
296.18 may adjust future rate payments, require the provider to submit a corrective action plan, or
296.19 pursue other enforcement actions as authorized by law.

296.20 (g) The commissioner must publish annual aggregate reports summarizing audit findings
296.21 and trends related to staffing provided under this section.

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

296.23 Sec. 36. Minnesota Statutes 2024, section 256B.4914, subdivision 13, is amended to read:

296.24 Subd. 13. **Transportation.** The commissioner shall require that the purchase of
296.25 transportation services be cost-effective and be limited to market rates where the
296.26 transportation mode is generally available and accessible. Effective January 1, 2027, or
296.27 upon federal approval, whichever is later, the billing limit for waiver transportation is equal
296.28 to a maximum of 28 one-way trips per week per participant.

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

297.1 Sec. 37. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
297.2 to read:

297.3 Subd. 21. **Integrated community supports access services; service standards and**
297.4 **billing criteria.** (a) This subdivision is effective October 1, 2027, or upon federal approval,
297.5 whichever is later.

297.6 (b) For the purposes of this section, "integrated community supports access services"
297.7 means the onsite or on-call availability of trained staff to address an individual's incidental,
297.8 unplanned support needs in an integrated community supports setting.

297.9 (c) A provider billing integrated community supports access services for on-call staff
297.10 must ensure that on-call staff are only assigned to one setting and can respond in-person to
297.11 the setting within 30 minutes of receiving a request for support. A provider must ensure
297.12 that staff providing onsite or on-call availability are specifically trained to support the
297.13 individual for each integrated community supports access services unit billed.

297.14 (d) Providers must collect and maintain documentation on each instance of incidental,
297.15 unplanned support provided to an individual by onsite or on-call staff. A documented instance
297.16 of staff providing incidental, unplanned support is not required for each day the integrated
297.17 community supports access services unit is billed.

297.18 (e) Documentation required under this subdivision must include:

297.19 (1) the individual's name;

297.20 (2) the date and time the individual requested incidental, unplanned support from onsite
297.21 or on-call staff;

297.22 (3) the date and time of the incidental, unplanned support provision;

297.23 (4) the name of the staff member providing the incidental, unplanned support;

297.24 (5) a description of what incidental, unplanned support was provided; and

297.25 (6) an indication if provision of incidental, unplanned support did or did not result in
297.26 the need for direct one-to-one support billed under subdivision 8a.

297.27 (f) A provider must document each instance of incidental, unplanned support provision
297.28 within 72 hours. If documentation is completed more than 72 hours after provision of
297.29 incidental, unplanned support, the provider must document extenuating circumstances that
297.30 resulted in the delay in documentation under this subdivision.

297.31 (g) Documentation must be maintained either electronically or in paper form. The
297.32 provider must produce the documentation upon request by the commissioner or lead agency.

298.1 Sec. 38. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
298.2 to read:

298.3 Subd. 22. **Administrative fees charged by providers and vendors.** Effective July 1,
298.4 2027, or upon federal approval, whichever is later, the commissioner must limit
298.5 administrative fees charged by enrolled providers and vendors approved by lead agencies
298.6 to no more than six percent of the total cost of the service or purchased goods. This limit
298.7 applies to the following services and other new market rate services as determined by the
298.8 commissioner:

298.9 (1) chore services billed daily;

298.10 (2) transitional services; and

298.11 (3) transportation.

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

298.13 Sec. 39. Minnesota Statutes 2024, section 256B.492, is amended by adding a subdivision
298.14 to read:

298.15 Subd. 4. **Integrated community supports setting approval moratorium and**
298.16 **exception.** (a) For purposes of this subdivision, "integrated community supports setting"
298.17 means a multifamily housing building where a provider delivers integrated community
298.18 supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and for which a
298.19 provider has a provider-controlled or provider-associated financial interest as defined under
298.20 section 245A.02, subdivision 10b.

298.21 (b) The commissioner must not approve a new integrated community supports setting
298.22 or approve an expansion of an existing integrated community supports setting except as
298.23 provided in this subdivision.

298.24 (c) The commissioner may approve an exception to the moratorium only when the
298.25 applicant demonstrates indirect control of the setting and compliance with:

298.26 (1) the federal home and community-based services requirements under Code of Federal
298.27 Regulations, title 42, section 441.301(c);

298.28 (2) the prohibition on the use of medical assistance money for room and board under
298.29 section 256B.4912, subdivision 17;

298.30 (3) independent lease requirements consistent with chapter 504B; and

298.31 (4) all documentation requirements under section 245D.12.

299.1 (d) To approve an exception, the commissioner must determine that the lead agency has
299.2 requested the additional capacity to meet the specific disability-related needs of the person.
299.3 Priority must be given to geographic regions with insufficient integrated community supports
299.4 capacity based on statewide or regional needs determination processes.

299.5 (e) Nothing in this subdivision authorizes the commissioner to revoke approval of a
299.6 previously approved setting following a change of ownership permissible under section
299.7 245A.043.

299.8 (f) A determination under this subdivision is final and not subject to appeal.

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

299.10 Sec. 40. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 7, is amended
299.11 to read:

299.12 Subd. 7. **Community first services and supports; covered services.** Services and
299.13 supports covered under CFSS include:

299.14 (1) assistance to accomplish activities of daily living (ADLs), instrumental activities of
299.15 daily living (IADLs), and health-related procedures and tasks through hands-on assistance
299.16 to accomplish the task or constant supervision and cueing to accomplish the task;

299.17 (2) assistance to acquire, maintain, or enhance the skills necessary for the participant to
299.18 accomplish activities of daily living, instrumental activities of daily living, or health-related
299.19 tasks;

299.20 (3) expenditures for items, services, supports, environmental modifications, or goods,
299.21 including assistive technology. These expenditures must:

299.22 (i) relate to a need identified in a participant's CFSS service delivery plan; and

299.23 (ii) increase independence or substitute for human assistance, to the extent that
299.24 expenditures would otherwise be made for human assistance for the participant's assessed
299.25 needs;

299.26 (4) observation and redirection for behavior or symptoms where there is a need for
299.27 assistance;

299.28 (5) back-up systems or mechanisms, such as the use of pagers or other electronic devices,
299.29 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;

(7) services described under subdivision 17 provided by a consultation services provider meeting the requirements of subdivision 17a;

(8) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

(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~~

(10) shared services meeting the shared services requirements of this section; and

~~(10)~~ (11) worker training and development services as described in subdivision 18a.

Sec. 41. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

Subd. 7c. **Shared services under the agency-provider model.** (a) The commissioner shall authorize shared services arrangements if the commissioner determines that a shared services arrangement is appropriate to meet all the participants' needs and sufficient to maintain the participants' health and safety. The commissioner must include a decision regarding authorization of shared services during the process of authorizing CFSS under subdivision 8. The commissioner must not reduce the total number of authorized units for a participant who elects to receive shared services.

(b) An agency-provider must offer a participant or the participant's representative the option of shared services, one-on-one services, or a combination of both shared services and one-on-one services when shared services are authorized by the commissioner. The option of shared services may be elected at the sole discretion of either the participant or the participant's representative. The participant or the participant's representative may withdraw from participating in a shared services arrangement at any time.

Sec. 42. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

Subd. 7d. **Shared services rates under the agency-provider model.** The commissioner shall provide a rate system for shared services. For two participants sharing services, the rate paid to an agency-provider for the shared services must not exceed one and one-half

301.1 times the rate paid for serving a single participant. For three participants sharing services,
301.2 the rate paid to an agency-provider for the shared services must not exceed twice the rate
301.3 paid for serving a single participant. These rates apply only when all criteria for shared
301.4 services are met.

301.5 Sec. 43. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision
301.6 to read:

301.7 Subd. 7e. **Pass-through for shared services under the agency-provider model.** (a)
301.8 Of the additional revenue for shared services provided to two participants, the
301.9 agency-provider must use 90 percent for the purposes specified in paragraph (b). Of the
301.10 additional revenue for shared services provided to three participants, the agency-provider
301.11 must use 90 percent for the purposes specified in paragraph (b).

301.12 (b) An agency-provider must use the percentages of additional revenue for shared services
301.13 specified in paragraph (a) for the wages and wage-related costs of the support worker
301.14 providing the shared services. The agency-provider must not use additional revenue for
301.15 shared services to pay for mileage reimbursements, uniform allowances, health and dental
301.16 insurance, life insurance, disability insurance, long-term care insurance, contributions to
301.17 employee retirement accounts when the contribution is not a function of wages, or any other
301.18 employee benefits.

301.19 Sec. 44. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision
301.20 to read:

301.21 Subd. 7f. **Shared services under the budget model.** (a) A participant who intends to
301.22 elect shared services under the budget model, or the participant's representative, must include
301.23 a statement of this intention in the CFSS service delivery plan, must develop a plan for
301.24 shared services when developing or amending the CFSS service delivery plan, and must
301.25 follow the CFSS process for approval of the plan as required under subdivision 6.

301.26 (b) The commissioner shall authorize shared services arrangements if the commissioner
301.27 determines that a shared services arrangement is appropriate to meet all the participants'
301.28 needs and sufficient to maintain the participants' health and safety. The commissioner must
301.29 include a decision regarding authorization of shared services during the process of authorizing
301.30 CFSS under subdivision 8. The commissioner must not reduce the total authorized dollar
301.31 amount available to a participant who elects to receive shared services.

301.32 (c) The participants, or participants' representatives as needed, who elect to share services
301.33 under the budget model must jointly develop a shared services agreement with the support

of the participants' representatives as needed. Any participant or any participant's representative may at any time withdraw from participating in a shared services agreement.

(d) The commissioner must develop and publish recommendations for negotiating wages for support workers providing shared services under the budget model.

Sec. 45. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

Subd. 7g. **Pass-through for shared services under the budget model.** For shared services provided under the budget model, participant employers must pay the individual provider support worker providing the shared services a percentage of the minimum wage specified in the agreement negotiated under chapter 179A, as made applicable to individual providers under section 179A.54, that is in effect at the time the services are provided. The required percentages are specified in clauses (1) and (2):

(1) for shared services provided by an individual provider support worker to two participant employers, the two participant employers must collectively pay the individual provider support worker at least 150 percent of the applicable minimum wage; and

(2) for shared services provided by an individual provider support worker to three participant employers, the three participant employers must collectively pay the individual support worker at least 200 percent of the applicable minimum wage.

Sec. 46. **[256B.8502] COMMUNITY FIRST SERVICES AND SUPPORTS; DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of this section and sections 256B.85 and 256B.851, the terms in this section have the meanings given.

Subd. 2. **Additional revenue for shared services.** "Additional revenue for shared services" means the difference between the rate paid to an agency-provider for serving a single participant and the sum of the rates paid to an agency-provider for shared services provided to more than one recipient.

Subd. 3. **Individual provider support worker.** "Individual provider support worker" means a support worker who is an individual provider as defined in section 256B.0711, subdivision 1.

Subd. 4. **Wages and wage-related costs.** "Wages and wage-related costs" means increased wages and any corresponding increase in the employer's or participant employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers'

303.1 compensation premiums, and contributions to employee retirement accounts when the
303.2 contribution is a function of wages.

303.3 Sec. 47. **[256R.60] NURSING FACILITY WORKFORCE WAGE SUPPLEMENT**
303.4 **PROGRAM.**

303.5 Subdivision 1. **Program established.** The commissioner must establish a program to
303.6 provide supplemental wage payments to nursing home employees as provided in this section.

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

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

303.10 (c) "Covered employee" means a nursing home worker, as defined in section 181.211,
303.11 subdivision 9, who worked at least 260 hours for a covered employer between January 1,
303.12 2026, and June 30, 2026.

303.13 (d) "Covered employer" means a nursing home employer as defined in section 181.211,
303.14 subdivision 8.

303.15 Subd. 3. **Eligibility for supplemental wage payments.** (a) A covered employee is
303.16 eligible to receive a onetime payment of up to \$400 if, during the period from January 1,
303.17 2026, to June 30, 2026, the employee was:

303.18 (1) in a position impacted by the January 1, 2026, wage standards described by Minnesota
303.19 Rules, parts 5200.2060 to 5200.2090; and

303.20 (2) paid at an hourly wage that was less than the applicable January 1, 2026, wage
303.21 standards described by Minnesota Rules, parts 5200.2060 to 5200.2090.

303.22 (b) A covered employee who does not meet the criteria in paragraph (a) is eligible to
303.23 receive a onetime payment of up to \$200.

303.24 (c) If appropriations are not sufficient to provide the maximum payment amount for all
303.25 approved applications, the commissioner must first ensure payments are distributed in an
303.26 equal amount, up to \$400, to all approved applicants meeting the criteria in paragraph (a).

303.27 (d) If additional funding exists after making payments under paragraph (c), the
303.28 commissioner must use the additional funding available to distribute payments in an equal
303.29 amount, up to \$200, to all covered employees not meeting the criteria in paragraph (a).

303.30 Subd. 4. **Employee and wage reporting by covered employees.** (a) A covered employer
303.31 must, by July 31, 2026, provide the commissioner with wage and hour data for the January

304.1 1, 2026, to June 30, 2026, period for each covered employee in a form and manner determined
304.2 by the commissioner.

304.3 (b) The commissioner may request additional information from covered employers to
304.4 validate the data provided under paragraph (a). A covered employer must respond to requests
304.5 from the commissioner under this paragraph.

304.6 (c) A covered employer that fails to comply with this subdivision may be subject to
304.7 payment reduction under section 256R.09, subdivision 4.

304.8 Subd. 5. **Application and payment processes.** (a) As soon as practicable after final
304.9 enactment of this act, the commissioner must establish a process for accepting applications
304.10 for payments under this section and begin accepting applications.

304.11 (b) The commissioner must:

304.12 (1) establish a multilingual temporary help line for applicants; and

304.13 (2) offer multilingual applications and multilingual instructions.

304.14 (c) To qualify for a payment under this section, a covered employee must submit an
304.15 application in a form and manner determined by the commissioner. As part of the application,
304.16 an applicant must certify to the commissioner that the applicant is a covered employee and
304.17 is eligible for payment under this section.

304.18 (d) The commissioner may contract with a third party to implement part or all of the
304.19 application and payment processes required under this section.

304.20 (e) The commissioner's determination of eligibility for payments and amounts is final
304.21 and is not subject to appeal.

304.22 (f) No later than 15 days after the application period is opened under this subdivision,
304.23 covered employers must provide notice, in a form and manner approved by the commissioner,
304.24 advising all current employees who may be eligible for payments under this section of the
304.25 assistance potentially available to them and how to apply for benefits. A covered employer
304.26 must provide notice using the same means the covered employer uses to provide other
304.27 work-related notices to employees.

304.28 (g) Notice provided under paragraph (f) must be at least as conspicuous as:

304.29 (1) posting a copy of the notice at each work site where employees work and where the
304.30 notice may be readily observed and reviewed by all employees working at the site; or

304.31 (2) providing a paper or electronic copy of the notice to all employees.

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

(1) the covered employee was eligible to receive payment under this section; and

(2) the covered employee received payments only in the amount permitted under this section.

(b) If the commissioner determines that a covered employee received payments not in compliance with this section, the commissioner must attempt to recoup the payment.

Subd. 7. **Payments not to be considered income.** (a) Notwithstanding any law to the contrary, payments provided under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

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

(2) general assistance and Minnesota supplemental aid under chapter 256D;

(3) food support under chapter 142F;

(4) housing support under chapter 256I;

(5) the Minnesota family investment program and diversionary work program under chapter 142G; and

(6) economic assistance programs under chapter 256P.

(b) The commissioner must not consider grant awards under this section as income or assets under section 256B.056, subdivision 1a, paragraph (a); 3; or 3c, or for persons with eligibility determined under section 256B.057, subdivision 3, 3a, 3b, 4, or 9.

Subd. 8. **Expiration.** This section expires June 30, 2028.

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

Sec. 48. Minnesota Statutes 2024, section 256S.15, is amended by adding a subdivision to read:

Subd. 3. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval, whichever is later, billable unit maximums are established for the following services authorized under section 256B.0913 and this chapter:

(1) for adult companion services, a maximum of six hours per day per recipient and a maximum of 936 hours annually per recipient;

306.1 (2) for chore services, a maximum of 24 units per week per recipient, where a unit is
306.2 defined as a 15-minute increment;

306.3 (3) for homemaker services, cleaning and home management may be provided for a
306.4 maximum of 16 hours combined per week per recipient;

306.5 (4) for personal emergency response system services, a maximum of one unit per month
306.6 per recipient; and

306.7 (5) for waiver transportation, a maximum of 28 one-way trips per week per participant.

306.8 (b) The limits in this subdivision do not limit a person's use of other waiver services.
306.9 Billing limits under this subdivision apply only to the individual service listed and do not
306.10 prohibit the recipient from accessing other services for which they are eligible on the same
306.11 day, week, or month, subject to other applicable requirements.

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

306.13 Sec. 49. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision
306.14 to read:

306.15 Subd. 4. **Documentation of staffing; auditing and rate review for residential support**
306.16 **services.** (a) For purposes of this subdivision, residential support services include 24-hour
306.17 customized living services, customized living services, family adult foster care, and corporate
306.18 adult foster care.

306.19 (b) Effective January 1, 2029, a provider enrolled to provide residential support services
306.20 under this subdivision must maintain documentation of direct staffing hours provided to
306.21 each person receiving services, including but not limited to documentation identifying:

306.22 (1) the name, role, and unique identifier for each staff person who provided services to
306.23 match records to payroll, time and attendance systems, and any other source documentation;

306.24 (2) the date services were provided;

306.25 (3) the total number of hours of direct support provided;

306.26 (4) awake overnight staffing hours provided, if applicable;

306.27 (5) asleep overnight staffing hours provided, if applicable; and

306.28 (6) any other staffing information required by the commissioner.

306.29 (c) A provider must maintain documentation in a manner and format determined by the
306.30 commissioner for at least six years. If a provider changes payroll vendors, merges operations,
306.31 or changes staffing identifiers, the provider must maintain a documented link between prior

307.1 and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and
307.2 role classification for each staff person.

307.3 (d) A provider must submit the documentation required under paragraph (b) to the
307.4 commissioner annually, in a manner and format determined by the commissioner. The
307.5 commissioner must establish multiple submission windows throughout the calendar year
307.6 and may assign providers to a submission window for administrative efficiency and system
307.7 capacity. Documentation must reflect staffing provided during the prior calendar year and
307.8 must be submitted no later than the final business day of the provider's assigned submission
307.9 window. The commissioner may conduct random or targeted validations and audits of
307.10 submitted data and may require supplemental documentation as necessary to verify accuracy
307.11 and compliance.

307.12 (e) The commissioner must conduct periodic analysis of documentation submitted under
307.13 this subdivision and may validate staffing data through random audits or other verification
307.14 methods.

307.15 (f) Based on the analysis under paragraph (e), the commissioner may provide
307.16 recommendations to lead agencies regarding modifications to the rate of the person receiving
307.17 services, including increases or decreases necessary to align the rate with staffing provided
307.18 to the person as demonstrated by the submitted historical staffing documentation.
307.19 Recommendations must be based on the requirements of this section and applicable federal
307.20 and state requirements governing rate setting.

307.21 (g) If a provider fails to submit documentation requested within the submission window
307.22 under paragraph (d), the commissioner must issue a written notice of noncompliance. If
307.23 documentation is not received within 60 days following the notice of noncompliance, the
307.24 commissioner may temporarily suspend payments to the provider until the required
307.25 documentation is submitted. The commissioner must make withheld payments to the provider
307.26 once the required documentation is received. If the noncompliance persists, the commissioner
307.27 may adjust future rate payments, require the provider to submit a corrective action plan, or
307.28 pursue other enforcement actions as authorized by law.

307.29 (h) The commissioner must publish annual aggregate reports summarizing audit findings
307.30 and trends related to staffing provided under this section.

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

308.1 Sec. 50. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision
308.2 to read:

308.3 Subd. 5. **Administrative fees charged by providers or vendors.** The commissioner
308.4 must limit administrative fees charged by enrolled providers or vendors approved by lead
308.5 agencies to no more than six percent of the total cost of the service or purchased goods.
308.6 This limit applies to the following services but allows for the addition of other services
308.7 determined by the commissioner:

308.8 (1) chore services billed daily;

308.9 (2) transitional services; and

308.10 (3) transportation.

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

308.12 Sec. 51. Laws 2021, First Special Session chapter 7, article 13, section 73, as amended
308.13 by Laws 2025, First Special Session chapter 9, article 2, section 56, is amended to read:

308.14 Sec. 73. **WAIVER REIMAGINE PHASE II.**

308.15 (a) Effective January 1, 2027, or upon federal approval, whichever is later, the
308.16 commissioner of human services must implement a two-home and community-based services
308.17 waiver program structure, as authorized under section 1915(c) of the federal Social Security
308.18 Act, that serves persons who are determined by a certified assessor to require the levels of
308.19 care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate
308.20 care facility for persons with developmental disabilities.

308.21 (b) The commissioner of human services must implement an individualized budget
308.22 methodology, as authorized under section 1915(c) of the federal Social Security Act, that
308.23 serves persons who are determined by a certified assessor to require the levels of care
308.24 provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care
308.25 facility for persons with developmental disabilities.

308.26 (c) The commissioner must develop an individualized budget methodology exception
308.27 to support access to self-directed home care nursing services. Lead agencies must submit
308.28 budget exception requests to the commissioner in a manner identified by the commissioner.
308.29 Eligibility for the budget exception in this paragraph is limited to persons meeting all of the
308.30 following criteria in the person's most recent assessment:

(1) the person is assessed to need the level of care delivered in a hospital setting as evidenced by the submission of the Department of Human Services form 7096, primary medical provider's documentation of medical monitoring and treatment needs;

(2) the person is assessed to receive a support range budget of E or H; and

(3) the person does not receive community residential services, family residential services, integrated community supports services, or customized living services.

(d) Home care nursing services funded through the budget exception developed under paragraph (c) must be ordered by a physician, physician assistant, or advanced practice registered nurse. If the participant chooses home care nursing, the home care nursing services must be performed by a registered nurse or licensed practical nurse practicing within the registered nurse's or licensed practical nurse's scope of practice as defined under Minnesota Statutes, sections 148.171 to 148.285. If after a person's annual reassessment under Minnesota Statutes, section 256B.0911, any requirements of this paragraph or paragraph (c) are no longer met, the commissioner must terminate the budget exception.

(e) The commissioner of human services may seek all federal authority necessary to implement this section.

(f) The commissioner must ensure that the new waiver service menu and individual budgets allow people to live in their own home, family home, or any home and community-based setting of their choice. The commissioner must ensure, within available resources and subject to state and federal regulations and law, that waiver reimagine does not result in unintended service disruptions.

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

(1) develop and implement an online support planning and tracking tool to provide information in an accessible format to support informed choice for people using disability waiver services that allows access to the total budget available to a person, the services for which they are eligible, and the services they have chosen and used. This information must be provided to persons currently using disability waiver services at least 12 months prior to the date their services will be subjected to the budget;

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

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

310.1 (h) The commissioner must establish a phased approach to implementing the two-waiver
310.2 program structure. The commissioner must consult with the Olmstead Implementation
310.3 Office prior to seeking federal approval to ensure the phased approach promotes community
310.4 integration and continuity of care.

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

310.6 Sec. 52. Laws 2026, chapter 95, article 4, section 2, is amended to read:

310.7 Sec. 2. Minnesota Statutes 2024, section 245A.03, is amended by adding a subdivision to
310.8 read:

310.9 Subd. 7c. **Licensing moratorium exceptions.** (a) The commissioner may approve
310.10 exceptions to the foster care and community residential settings moratoria described under
310.11 subdivision 7b as provided in this subdivision.

310.12 (b) When approving an exception under this subdivision to the foster care or community
310.13 residential setting moratorium described in subdivision 7b, the commissioner shall consider
310.14 the resource need determination process in subdivision 7d, the availability of foster care
310.15 licensed beds in the geographic area in which the licensee seeks to operate, the results of
310.16 the person's choices during the person's annual assessment and service plan review, and the
310.17 recommendation of the local county board. The determination by the commissioner is final
310.18 and not subject to appeal.

310.19 (c) Permissible exceptions to the moratorium include:

310.20 (1) a license for a person in a foster care setting that is not the primary residence of the
310.21 license holder and where at least 80 percent of the residents are 55 years of age or older;

310.22 (2) new foster care licenses or community residential setting licenses determined to be
310.23 needed by the commissioner under subdivision 7d for the closure of a nursing facility, an
310.24 intermediate care facility for individuals with developmental disabilities, or regional treatment
310.25 center; restructuring of state-operated services that limits the capacity of state-operated
310.26 facilities; or movement to the community of people who no longer require the level of care
310.27 provided in state-operated facilities as provided under section 256B.092, subdivision 13,
310.28 or 256B.49, subdivision 24; ~~and~~

310.29 (3) new foster care licenses or community residential setting licenses determined to be
310.30 needed by the commissioner under subdivision 7d for persons requiring hospital-level care;
310.31 and

(4) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 and residing in the customized living setting before July 1, 2026, for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2027. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people under the brain injury or community access for disability inclusion waiver plans under section 256B.49 in a single-family home operational on or before June 30, 2026. For purposes of this clause, "operational" has the meaning given in section 256B.49, subdivision 28;

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

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

Sec. 53. WAIVER CASE MANAGEMENT ADVISORY WORKING GROUP.

Subdivision 1. Establishment; purpose. The commissioner of human services shall convene a waiver case management advisory working group. The purpose of the working group is to evaluate and make recommendations regarding the quality, workforce sustainability, accountability, and long-term stability of home and community-based waiver case management services provided under Minnesota Statutes, sections 256B.0913, 256B.092, 256B.0922, and 256B.49, and chapter 256S.

Subd. 2. Membership. The commissioner shall appoint members representing diverse geographic regions of the state, including metropolitan and greater Minnesota areas, with at least 30 percent of the members living or working outside the seven-county metropolitan area and including:

(1) representatives of the Department of Human Services;

(2) lead agencies, as defined in Minnesota Statutes, section 256B.0911, subdivision 10;

- 312.1 (3) contracted waiver case management providers;
- 312.2 (4) waiver case managers with current direct service responsibilities;
- 312.3 (5) individuals receiving waiver services or their family members or advocates;
- 312.4 (6) representatives of disability advocacy organizations;
- 312.5 (7) representatives of the Minnesota Disability Law Center;
- 312.6 (8) representatives of culturally specific or Tribal communities; and
- 312.7 (9) workforce representatives with experience in human services.

312.8 Subd. 3. **Compensation; expenses.** Members of the working group may receive
312.9 compensation and expense reimbursement as provided in Minnesota Statutes, section 15.059,
312.10 subdivision 3.

312.11 Subd. 4. **Meetings; administrative support.** (a) The first meeting of the working group
312.12 must be convened no later than August 1, 2026. The working group must meet at least
312.13 monthly. Meetings are subject to Minnesota Statutes, chapter 13D. The working group may
312.14 meet by telephone or interactive technology consistent with Minnesota Statutes, section
312.15 13D.015.

312.16 (b) The Department of Human Services shall provide staff and administrative support
312.17 to convene the working group, facilitate working group meetings, and prepare the final
312.18 report.

312.19 Subd. 5. **Duties.** The working group shall:

312.20 (1) evaluate the impact of current funding levels, workforce capacity, administrative
312.21 requirements, and caseload expectations on service delivery and quality outcomes;

312.22 (2) examine accountability and oversight mechanisms and grievance processes across
312.23 delivery models;

312.24 (3) review available data related to workforce vacancies, turnover, compensation, and
312.25 service access;

312.26 (4) identify barriers to maintaining high-quality and culturally responsive case
312.27 management services;

312.28 (5) examine case management training requirements and core competencies;

312.29 (6) evaluate client transfer and service continuity processes; and

313.1 (7) develop recommendations, including potential legislative or administrative changes,
313.2 to ensure a stable, accountable, and high-quality waiver case management system that
313.3 supports person-centered planning and informed choice.

313.4 Subd. 6. **Report.** By September 1, 2027, the commissioner shall submit a report
313.5 summarizing the working group's findings and recommendations to the chairs and ranking
313.6 minority members of the legislative committees with jurisdiction over human services policy
313.7 and finance.

313.8 Subd. 7. **Expiration.** The working group expires upon submission of the report required
313.9 under subdivision 6.

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

313.11 Sec. 54. **DIRECTION TO COMMISSIONER; HCBS WAIVER CASE**
313.12 **MANAGEMENT EVALUATION AND REPORT.**

313.13 (a) The commissioner of human services must evaluate reimbursement rates and lead
313.14 agency duties associated with home and community-based services (HCBS) case management
313.15 under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S. The
313.16 commissioner must develop an updated payment methodology for waiver case management
313.17 that reasonably covers the cost to provide high-quality, person-centered, and culturally
313.18 responsive case management services. The report must, at a minimum, include:

313.19 (1) an evaluation of costs and workforce pressures that impact the delivery of case
313.20 management services;

313.21 (2) an evaluation of costs to provide culturally responsive case management services;

313.22 (3) an evaluation of current reimbursement rates, methodologies, and the extent to which
313.23 rates cover costs to provide services and attract and retain case managers;

313.24 (4) an evaluation of current caseload sizes and recommended best practices for caseload
313.25 and case mix;

313.26 (5) identification and evaluation of the required professional qualifications, experience,
313.27 and training of case management professionals; and

313.28 (6) recommended HCBS waiver rate methodology, specified cost components, weighted
313.29 values, and modeled rate frameworks.

313.30 (b) The commissioner must consult with interested parties, including but not limited to
313.31 lead agencies, contracted case management services providers, individuals receiving services
313.32 and their families, advocacy organizations, and relevant experts. The commissioner must

314.1 consider the recommendations of the waiver case management advisory working group
314.2 under section 53 when developing recommendations under this section.

314.3 (c) The commissioner may contract with rate experts to develop and model recommended
314.4 rates.

314.5 (d) By December 15, 2028, the commissioner of human services must submit a report
314.6 to the chairs and ranking minority members of the legislative committees with jurisdiction
314.7 over health and human services with the findings and recommendations of the evaluation.

314.8 **EFFECTIVE DATE.** This section is effective July 1, 2027.

314.9 Sec. 55. **INTEGRATED COMMUNITY SUPPORTS REFORM STUDY.**

314.10 Subdivision 1. **Review and evaluation.** (a) The commissioner of human services must
314.11 review the medical assistance integrated community supports (ICS) service provided under
314.12 the home and community-based waivers authorized under Minnesota Statutes, sections
314.13 256B.092 and 256B.49, and evaluate the need for statutory, regulatory, and programmatic
314.14 reforms. At a minimum, the evaluation must include:

314.15 (1) an examination of current provider standards, service delivery models, and oversight
314.16 mechanisms applicable to ICS providers;

314.17 (2) an assessment of the effectiveness of ICS in supporting individuals to live
314.18 independently in community settings, including outcomes related to service utilization and
314.19 health and safety;

314.20 (3) a review of payment methodologies, including rate structures, administrative
314.21 components, and alignment with federal Medicaid requirements under home and
314.22 community-based services waivers and state plan authorities;

314.23 (4) an environmental scan of comparable supportive housing and community-based
314.24 service models in other states, including best practices for program integrity, quality
314.25 assurance, and service coordination;

314.26 (5) an assessment of program integrity risks, including billing practices and service
314.27 verification; and

314.28 (6) identification of opportunities to improve coordination between ICS providers and
314.29 lead agencies.

314.30 (b) The commissioner may hire a third-party contractor to perform activities necessary
314.31 to complete the evaluation. Any contract with a contractor under this section is not subject

315.1 to the statewide contracting provisions under Minnesota Statutes, sections 16C.05,
315.2 subdivisions 1 to 4, and 16C.06.

315.3 Subd. 2. **Community consultation.** The commissioner must consult with the community
315.4 in conducting the review under this section. The community must include, at a minimum:

315.5 (1) individuals who receive ICS services and self-advocates;

315.6 (2) family members and caregivers of individuals who receive ICS services;

315.7 (3) ICS providers;

315.8 (4) counties and Tribal Nations serving as lead agencies; and

315.9 (5) advocacy organizations representing people with disabilities.

315.10 Subd. 3. **Reports.** (a) The commissioner must develop recommendations for legislative
315.11 and administrative changes to strengthen the ICS program. Recommendations may include
315.12 but are not limited to:

315.13 (1) establishing risk-based provider oversight and program integrity requirements;

315.14 (2) clarifying allowable services and service limits consistent with federal Medicaid
315.15 requirements, including prohibitions on payment for room and board;

315.16 (3) improving service verification, documentation, and accountability measures;

315.17 (4) enhancing recipient protections, including person-centered planning and grievance
315.18 processes;

315.19 (5) aligning ICS with home and community-based services settings requirements under
315.20 Code of Federal Regulations, title 42, section 441.301; and

315.21 (6) modifications to the ICS rate methodology.

315.22 (b) The commissioner must submit an initial report to the chairs and ranking minority
315.23 members of the legislative committees with jurisdiction over health and human services
315.24 policy and finance by March 1, 2027, and a final report by January 1, 2028. The reports
315.25 must include findings, community feedback, and specific legislative proposals related to
315.26 ICS reform.

315.27 Sec. 56. **MARKET RATE STUDY FOR HOME AND COMMUNITY-BASED**
315.28 **SERVICES.**

315.29 (a) The commissioner of human services must conduct a market rate study to evaluate
315.30 the adequacy, sustainability, and equity of payment rates for specific home and

316.1 community-based services under the home and community-based services waivers authorized
316.2 under Minnesota Statutes, sections 256B.092 and 256B.49.

316.3 (b) The study must include, at minimum, an analysis of the following services:

316.4 (1) employment support services delivered in remote or virtual settings;

316.5 (2) 24-hour emergency assistance;

316.6 (3) assistive technology;

316.7 (4) environmental accessibility adaptations;

316.8 (5) chore services;

316.9 (6) transitional services;

316.10 (7) independent living skills training; and

316.11 (8) specialist services, including positive support services and orientation and mobility
316.12 services.

316.13 (c) In planning and conducting the market rate study, the commissioner must consult
316.14 with interested parties, including but not limited to service providers, people with disabilities,
316.15 lead agencies, Tribal Nations, culturally specific and community-based providers, and
316.16 disability advocacy organizations. The consultation process must be designed to ensure
316.17 meaningful participation from providers in greater Minnesota and from providers serving
316.18 communities of color and Tribal Nations.

316.19 (d) In conducting the study, the commissioner must analyze provider costs, workforce
316.20 availability, wage competitiveness, regional market conditions, inflationary impacts, and
316.21 access issues. The commissioner must also evaluate whether current reimbursement
316.22 methodologies reflect actual costs of providing services and support long-term access to
316.23 qualified providers.

316.24 (e) By February 15, 2027, the commissioner must submit a report with findings and
316.25 recommendations, including but not limited to any proposed statutory changes, to the chairs
316.26 and ranking minority members of the legislative committees with jurisdiction over health
316.27 and human services policy and finance.

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

316.29 Sec. 57. **MNCHOICES REDESIGN WORKING GROUP.**

316.30 Subdivision 1. **Establishment.** The commissioner of human services shall convene a
316.31 MnCHOICES redesign working group to develop recommendations related to state provision

317.1 of MnCHOICES assessments under Minnesota Statutes, section 256B.0911, subdivision
317.2 14, paragraph (g).

317.3 Subd. 2. **Membership.** At a minimum, the working group must include the following
317.4 members:

317.5 (1) two individuals receiving waiver services or the individuals' family members or
317.6 advocates, appointed by the commissioner in consultation with organizations representing
317.7 individuals with lived experience of disability and waiver services;

317.8 (2) three county representatives, appointed by the Minnesota Association of County
317.9 Social Service Administrators, including:

317.10 (i) at least one representative of a lead agency located in a metropolitan county, as defined
317.11 in Minnesota Statutes, section 473.121, subdivision 4; and

317.12 (ii) at least two representatives of lead agencies located outside of a metropolitan county,
317.13 as defined in Minnesota Statutes, section 473.121, subdivision 4;

317.14 (3) one staff member from the Minnesota Social Service Association, appointed by the
317.15 Minnesota Social Service Association;

317.16 (4) at least three representatives from Tribal Nations, appointed by the commissioner;

317.17 (5) two representatives of disability advocacy organizations, appointed by the
317.18 commissioner; and

317.19 (6) additional nonvoting participants as determined by the commissioner, which may
317.20 include staff from the Department of Human Services and other interested parties.

317.21 Subd. 3. **Duties.** The working group shall make recommendations to shift the
317.22 responsibility and administration of conducting MnCHOICES assessments to the state.

317.23 Recommendations must include:

317.24 (1) defined roles and responsibilities between county, Tribal Nation, and state functions;

317.25 (2) revised payment methodologies and financing of duties;

317.26 (3) efficient workflows between local and state functions;

317.27 (4) service continuity for people seeking and receiving long-term services and supports;
317.28 and

317.29 (5) methods for gathering public feedback and providing public awareness.

317.30 Subd. 4. **Terms, compensation, and removal.** The terms, compensation, and removal
317.31 of the working group members are governed by Minnesota Statutes, section 15.059.

318.1 Subd. 5. **Meetings; administrative support.** (a) The first meeting of the working group
318.2 must be convened no later than August 1, 2026. The working group must meet at least
318.3 monthly. The working group may meet by telephone or interactive technology consistent
318.4 with Minnesota Statutes, section 13D.015.

318.5 (b) The Department of Human Services shall provide staff and administrative support
318.6 to convene the working group, facilitate working group meetings, and prepare the final
318.7 report.

318.8 Subd. 6. **Report.** By September 1, 2027, the commissioner must submit a report of the
318.9 working group's findings and recommendations, including but not limited to any legislative
318.10 changes necessary to implement the recommendations, to the chairs and ranking minority
318.11 members of the legislative committees with jurisdiction over human services policy and
318.12 finance.

318.13 Subd. 7. **Expiration.** The working group expires upon submission of the report required
318.14 under subdivision 6.

318.15 Sec. 58. **DIRECTION TO COMMISSIONER; ENVIRONMENTAL**
318.16 **ACCESSIBILITY ADAPTATIONS FOR HOMES.**

318.17 By October 1, 2026, the commissioner of human services must submit to the Centers
318.18 for Medicare and Medicaid Services waiver plan amendments for the brain injury, community
318.19 access for disability inclusion, community alternative care, and developmental disabilities
318.20 1915(c) waivers to implement the following reforms to environmental accessibility
318.21 adaptations for homes:

318.22 (1) separate the treatment of home modifications from the treatment of vehicle
318.23 modifications;

318.24 (2) replace the existing \$40,000 annual limit for home modifications with a \$40,000
318.25 three-year limit;

318.26 (3) replace the existing provisions that permit a two-year limit of \$80,000 to be authorized
318.27 during a two-year period with provisions permitting a six-year limit of \$80,000 to be
318.28 authorized in a five-year period;

318.29 (4) limit permissible authorizations for home modifications to only modifications meeting
318.30 an assessed need that cannot be met in a less costly way in the person's current home;

318.31 (5) limit the number of similar or duplicative home modifications to modifications that
318.32 are necessary for the health and safety of the person; and

319.1 (6) establish caps on the number, size, and cost of common home modifications.

319.2 **Sec. 59. DIRECTION TO COMMISSIONER; ENVIRONMENTAL**
319.3 **ACCESSIBILITY ADAPTATIONS FOR VEHICLES.**

319.4 (a) By October 1, 2026, the commissioner of human services must submit to the Centers
319.5 for Medicare and Medicaid Services waiver plan amendments for the brain injury, community
319.6 access for disability inclusion, community alternative care, and developmental disabilities
319.7 1915(c) waivers to implement the following reforms to environmental accessibility
319.8 adaptations for vehicles:

319.9 (1) separate the treatment of vehicle modifications from the treatment of home
319.10 modifications;

319.11 (2) replace the existing \$40,000 annual limit for vehicle modifications with a \$40,000
319.12 five-year limit; and

319.13 (3) permit multiple authorizations for vehicle modifications in a five-year period when
319.14 a vehicle is sold, provided that subsequent authorizations are limited to:

319.15 (i) for a purchased adapted vehicle, the portion of the original purchase cost attributable
319.16 to the vehicle modifications minus the book value of the purchase price attributable to the
319.17 vehicle modifications; or

319.18 (ii) for vehicle modifications, the original purchase and installation cost of the
319.19 modifications minus the book value of the modifications.

319.20 (b) For purposes of this section, "book value" means the original cost minus the product
319.21 of 20 percent of the original cost multiplied by the number of years during which the adapted
319.22 vehicle was used by the person.

319.23 **Sec. 60. DIRECTION TO COMMISSIONER; HOME AND COMMUNITY-BASED**
319.24 **SERVICES ACCESS RULE IMPLEMENTATION.**

319.25 The commissioner of human services must develop systems and capacity to comply
319.26 with the requirements of the federal access rule to improve access to care, quality and health
319.27 outcomes, and program integrity in medical assistance home and community-based services.
319.28 The initial phase of implementation efforts for home and community-based services must
319.29 include:

320.1 (1) updating critical incident oversight by implementing a system to track trends,
320.2 resolution of incidents, and other information to enhance protections and improve outcomes
320.3 for recipients;

320.4 (2) establishing a home and community-based services grievance procedure and work
320.5 unit to accept, investigate, and resolve grievances for home and community-based service
320.6 recipients related to service providers, lead agencies, and the department;

320.7 (3) establishing an advisory body for interested parties to advise on services, including
320.8 direct care workers, beneficiaries, authorized representatives, and other individuals impacted
320.9 by service rates;

320.10 (4) establishing an advisory body for current and former beneficiaries, family members,
320.11 and caregivers to advise the commissioner on policy and program administration;

320.12 (5) publishing all medical assistance fee-for-service fee schedule payment rates; and

320.13 (6) developing and reporting on home and community-based service program integrity
320.14 and quality measures to demonstrate state outcomes on wait list times; access to certain
320.15 services, including the average time from eligibility determination to service commencement;
320.16 service utilization; and other quality metrics.

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

320.18 Sec. 61. **REVISOR INSTRUCTION.**

320.19 (a) The revisor of statutes shall renumber the definitions in Minnesota Statutes, section
320.20 256B.85, subdivision 2, and the definitions in Minnesota Statutes, section 256B.851,
320.21 subdivision 2, as subdivisions in Minnesota Statutes, section 256B.8502, rearranging the
320.22 renumbered and existing definitions in Minnesota Statutes, section 256B.8502, as necessary
320.23 to place them in alphabetical order. The revisor of statutes shall revise all statutory
320.24 cross-references consistent with this recoding.

320.25 (b) If a provision of Minnesota Statutes, section 256B.85, subdivision 2, or 256B.851,
320.26 subdivision 2, is amended or repealed in the 2026 regular legislative session, the revisor of
320.27 statutes shall codify the amendment or repealer in Minnesota Statutes, section 256B.8502,
320.28 notwithstanding any other law to the contrary.

320.29 Sec. 62. **REPEALER.**

320.30 (a) Minnesota Statutes 2024, section 256B.0911, subdivision 21, is repealed.

321.1 (b) Minnesota Statutes 2025 Supplement, section 256B.0911, subdivisions 24a and 25a,
321.2 are repealed.

321.3 (c) Minnesota Statutes 2024, section 256B.0921, is repealed.

321.4 **EFFECTIVE DATE.** Paragraph (a) is effective January 1, 2027. Paragraph (b) is
321.5 effective the day following final enactment.

321.6 **ARTICLE 10**

321.7 **ELECTRONIC VISIT VERIFICATION**

321.8 Section 1. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is
321.9 amended to read:

321.10 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
321.11 means motor vehicle transportation provided by a public or private person that serves
321.12 Minnesota health care program beneficiaries who do not require emergency ambulance
321.13 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

321.14 (b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
321.15 a census-tract based classification system under which a geographical area is determined
321.16 to be urban, rural, or super rural. This paragraph expires July 1, 2026, for medical assistance
321.17 fee-for-service and January 1, 2027, for prepaid medical assistance.

321.18 (c) Medical assistance covers medical transportation costs incurred solely for obtaining
321.19 emergency medical care or transportation costs incurred by eligible persons in obtaining
321.20 emergency or nonemergency medical care when paid directly to an ambulance company,
321.21 nonemergency medical transportation company, or other recognized providers of
321.22 transportation services. Medical transportation must be provided by:

321.23 (1) nonemergency medical transportation providers who meet the requirements of this
321.24 subdivision;

321.25 (2) ambulances, as defined in section 144E.001, subdivision 2;

321.26 (3) taxicabs that meet the requirements of this subdivision;

321.27 (4) public transportation, within the meaning of "public transportation" as defined in
321.28 section 174.22, subdivision 7; or

321.29 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
321.30 subdivision 1, paragraph (p).

(d) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph. This paragraph expires upon the effective date of paragraph (e).

(e) Effective January 1, 2027, or upon federal approval, whichever is later, medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers must bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria and comply with the requirements under section 256B.073. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

~~(e)~~ (f) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

~~(f)~~ (g) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

323.1 (2) pay nonemergency medical transportation providers for services provided to
323.2 Minnesota health care programs beneficiaries to obtain covered medical services;

323.3 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
323.4 trips, and number of trips by mode; and

323.5 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
323.6 administrative structure assessment tool that meets the technical requirements established
323.7 by the commissioner, reconciles trip information with claims being submitted by providers,
323.8 and ensures prompt payment for nonemergency medical transportation services. This
323.9 paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
323.10 for prepaid medical assistance.

323.11 ~~(g)~~ (h) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid
323.12 medical assistance, the administrative agency of nonemergency medical transportation must:

323.13 (1) adhere to the policies defined by the commissioner;

323.14 (2) pay nonemergency medical transportation providers for services provided to
323.15 Minnesota health care program beneficiaries to obtain covered medical services; and

323.16 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
323.17 trips, and number of trips by mode.

323.18 ~~(h)~~ (i) Until the commissioner implements the single administrative structure and delivery
323.19 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
323.20 commissioner or an entity approved by the commissioner that does not dispatch rides for
323.21 clients using modes of transportation under paragraph ~~(n)~~ (o), clauses (4), (5), (6), and (7).
323.22 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
323.23 2027, for prepaid medical assistance.

323.24 ~~(i)~~ (j) The commissioner may use an order by the recipient's attending physician, advanced
323.25 practice registered nurse, physician assistant, or a medical or mental health professional to
323.26 certify that the recipient requires nonemergency medical transportation services.

323.27 Nonemergency medical transportation providers shall perform driver-assisted services for
323.28 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
323.29 at and return to the individual's residence or place of business, assistance with admittance
323.30 of the individual to the medical facility, and assistance in passenger securement or in securing
323.31 of wheelchairs, child seats, or stretchers in the vehicle.

323.32 ~~(j)~~ (k) Nonemergency medical transportation providers must take clients to the health
323.33 care provider using the most direct route, and must not exceed 30 miles for a trip to a primary

324.1 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
324.2 authorization from the local agency. This paragraph expires July 1, 2026, for medical
324.3 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

324.4 ~~(k)~~ (l) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
324.5 for prepaid medical assistance, nonemergency medical transportation providers must take
324.6 clients to the health care provider using the most direct route and must not exceed 30 miles
324.7 for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless
324.8 the client receives authorization from the administrator.

324.9 ~~(l)~~ (m) Nonemergency medical transportation providers may not bill for separate base
324.10 rates for the continuation of a trip beyond the original destination. Nonemergency medical
324.11 transportation providers must maintain trip logs, which include pickup and drop-off times,
324.12 signed by the medical provider or client, whichever is deemed most appropriate, attesting
324.13 to mileage traveled to obtain covered medical services. Clients requesting client mileage
324.14 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
324.15 services.

324.16 ~~(m)~~ (n) The administrative agency shall use the level of service process established by
324.17 the commissioner to determine the client's most appropriate mode of transportation. If public
324.18 transit or a certified transportation provider is not available to provide the appropriate service
324.19 mode for the client, the client may receive a onetime service upgrade.

324.20 ~~(n)~~ (o) The covered modes of transportation are:

324.21 (1) client reimbursement, which includes client mileage reimbursement provided to
324.22 clients who have their own transportation, or to family or an acquaintance who provides
324.23 transportation to the client;

324.24 (2) volunteer transport, which includes transportation by volunteers using their own
324.25 vehicle;

324.26 (3) unassisted transport, which includes transportation provided to a client by a taxicab
324.27 or public transit. If a taxicab or public transit is not available, the client can receive
324.28 transportation from another nonemergency medical transportation provider;

324.29 (4) assisted transport, which includes transport provided to clients who require assistance
324.30 by a nonemergency medical transportation provider;

324.31 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
324.32 dependent on a device and requires a nonemergency medical transportation provider with
324.33 a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

~~(p)~~ (p) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph ~~(n)~~ (o) according to paragraphs ~~(r)~~ (s) to ~~(t)~~ (u) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(p)~~ (q) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

~~(q)~~ (r) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(r)~~ (s) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) \$0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

326.1 (3) equivalent to the standard fare for unassisted transport when provided by public
326.2 transit, and \$12.10 for the base rate and \$1.43 per mile when provided by a nonemergency
326.3 medical transportation provider;

326.4 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;

326.5 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;

326.6 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

326.7 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
326.8 an additional attendant if deemed medically necessary. This paragraph expires July 1, 2026,
326.9 for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

326.10 ~~(s)~~ (t) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
326.11 for prepaid medical assistance, payments for nonemergency medical transportation must
326.12 be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle
326.13 used to provide the service.

326.14 ~~(t)~~ (u) The base rate for nonemergency medical transportation services in areas defined
326.15 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
326.16 paragraph ~~(t)~~ (s), clauses (1) to (7). The mileage rate for nonemergency medical transportation
326.17 services in areas defined under RUCA to be rural or super rural areas is:

326.18 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
326.19 rate in paragraph ~~(t)~~ (s), clauses (1) to (7); and

326.20 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
326.21 rate in paragraph ~~(t)~~ (s), clauses (1) to (7). This paragraph expires July 1, 2026, for medical
326.22 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

326.23 ~~(u)~~ (v) For purposes of reimbursement rates for nonemergency medical transportation
326.24 services under paragraphs ~~(t)~~ (s) to ~~(t)~~ (u), the zip code of the recipient's place of residence
326.25 shall determine whether the urban, rural, or super rural reimbursement rate applies. This
326.26 paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
326.27 for prepaid medical assistance.

326.28 ~~(v)~~ (w) The commissioner, when determining reimbursement rates for nonemergency
326.29 medical transportation, shall exempt all modes of transportation listed under paragraph ~~(n)~~
326.30 (o) from Minnesota Rules, part 9505.0445, item R, subitem (2).

326.31 ~~(w)~~ (x) Effective for the first day of each calendar quarter in which the price of gasoline
326.32 as posted publicly by the United States Energy Information Administration exceeds \$3.00

327.1 per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(t)~~ (s) by one
327.2 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
327.3 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
327.4 increase or decrease must be calculated using the average of the most recently available
327.5 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
327.6 Information Administration. This paragraph expires July 1, 2026, for medical assistance
327.7 fee-for-service and January 1, 2027, for prepaid medical assistance.

327.8 Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 17b, is amended to read:

327.9 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency
327.10 medical transportation providers must document each occurrence of a service provided to
327.11 a recipient according to this subdivision. Providers must maintain records sufficient to
327.12 distinguish individual trips with specific vehicles and drivers. The documentation may be
327.13 collected and maintained using electronic systems or software or in paper form but must be
327.14 made available and produced upon request. Program funds paid for transportation that is
327.15 not documented according to this subdivision may be subject to recovery by the commissioner
327.16 pursuant to section 256B.064.

327.17 (b) A nonemergency medical transportation provider must compile transportation trip
327.18 records that are written in English and legible according to the standard of a reasonable
327.19 person and that include each of the following elements:

327.20 (1) the recipient's name;

327.21 (2) the date or dates the service is provided, if different than the date the entry was made;

327.22 (3) either the printed name of the driver sufficient to distinguish the driver of service or
327.23 the driver's provider number;

327.24 (4) the date and the signature of the driver attesting that the record accurately represents
327.25 the services provided and the actual miles driven, and acknowledging that misreporting
327.26 information that results in ineligible or excessive payments may result in civil or criminal
327.27 action;

327.28 (5) the date and the signature of the recipient or authorized party attesting that
327.29 transportation services were provided as indicated on the transportation trip record, or the
327.30 signature of the medical services provider certifying that the recipient was transported to
327.31 the medical services provider destination. In the event that both the medical services provider
327.32 and the recipient or authorized party refuse or are unable to provide signatures, the driver

328.1 must document on the transportation trip record that signatures were requested and not
328.2 provided;

328.3 (6) the address, or the description if the address is not available, of both the origin and
328.4 destination, and the mileage for the most direct route from the origin to the destination;

328.5 (7) the name or number of the mode of transportation in which the service is provided;

328.6 (8) the license plate number of the vehicle used to transport the recipient;

328.7 (9) the time of the recipient pickup;

328.8 (10) the time of the recipient drop-off;

328.9 (11) the odometer reading of the vehicle used to transport the recipient taken at the time
328.10 of pickup;

328.11 (12) the odometer reading of the vehicle used to transport the recipient taken at the time
328.12 of drop-off;

328.13 (13) the name of the extra attendant when an extra attendant is used to provide special
328.14 transportation service; and

328.15 (14) the documentation indicating the method that was used to determine the most direct
328.16 route.

328.17 (c) In determining whether the commissioner will seek recovery, the documentation
328.18 requirements in this section apply retroactively to audit findings beginning January 1, 2020,
328.19 and to all audit findings thereafter.

328.20 (d) Effective January 1, 2027, or upon federal approval, whichever is later, records that
328.21 comply with section 256B.073 may be used to meet the requirements under this subdivision
328.22 if all required elements are included in the record.

328.23 Sec. 3. Minnesota Statutes 2024, section 256B.073, subdivision 1, is amended to read:

328.24 Subdivision 1. **Documentation; establishment and operation.** The commissioner of
328.25 human services shall establish ~~implementation requirements and standards for~~ and maintain
328.26 the requirements and standards for the ongoing operation of electronic visit verification to
328.27 comply with the 21st Century Cures Act, Public Law 114-255. Within available
328.28 appropriations, the commissioner shall take steps to comply with the electronic visit
328.29 verification requirements in the 21st Century Cures Act, Public Law 114-255.

329.1 Sec. 4. Minnesota Statutes 2024, section 256B.073, subdivision 2, is amended to read:

329.2 Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have
329.3 the meanings given ~~them~~.

329.4 (b) "Data aggregator" means the entity designated by the commissioner to collect, store,
329.5 and transmit electronic visit verification data from providers and third-party systems to the
329.6 commissioner in accordance with the standards and requirements established under this
329.7 section.

329.8 ~~(b)~~ (c) "Electronic visit verification" or "EVV" means the electronic documentation of
329.9 the process required under this section and United States Code, title 42, section 1396b(1),
329.10 used to electronically verify the:

329.11 (1) type of service performed;

329.12 (2) individual receiving the service;

329.13 (3) date of the service;

329.14 (4) location of the service delivery;

329.15 (5) individual providing the service; and

329.16 (6) time the service begins and ends.

329.17 (d) "Electronic visit verification data" means information collected through an electronic
329.18 visit verification system, including data elements required under United States Code, title
329.19 42, section 1396b(1), and any additional data elements specified by the commissioner under
329.20 this section.

329.21 ~~(e)~~ (e) "Electronic visit verification system" means a system that provides electronic
329.22 verification of services used to collect, verify, and transmit electronic visit verification data
329.23 to the commissioner or the commissioner's designated data aggregator that complies with
329.24 the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

329.25 (f) "Electronic visit verification vendor" means any entity that develops, provides, or
329.26 supports an electronic visit verification system, including the state-provided vendor and
329.27 any third-party vendor.

329.28 (g) "Financial management services provider" means an entity enrolled with the
329.29 commissioner to provide financial management services under section 256B.85 or other
329.30 applicable law and responsible for fiscal, payroll, and reporting functions on behalf of
329.31 participant employers.

330.1 (h) "Home health agency" means a home care provider agency that is Medicare certified
330.2 under Code of Federal Regulations, title 42, part 484, and licensed as a home care provider
330.3 under chapter 144A.

330.4 (i) "Individual" means a person who receives services subject to electronic visit
330.5 verification under the medical assistance program.

330.6 (j) "Managed care organization" means a public or private organization that contracts
330.7 with the commissioner under section 256B.69 or other applicable law to deliver health care
330.8 services to individuals eligible for medical assistance or MinnesotaCare.

330.9 (k) "Manual visit" means a visit:

330.10 (1) entered administratively and not by the caregiver at the time of service delivery; or

330.11 (2) where data elements are edited after the time of service delivery.

330.12 (l) "Provider" means an individual or organization that meets one or more of the following
330.13 conditions:

330.14 (1) is enrolled as a Minnesota health care programs provider;

330.15 (2) provides services through a managed care organization under contract with the
330.16 commissioner under section 256B.69;

330.17 (3) is a financial management services provider; or

330.18 (4) is a participant employer under section 256B.85, subdivision 7, or an employer of
330.19 record that is directing services under section 256B.49, subdivision 16.

330.20 ~~(d)~~ (m) "Service" means one of the following:

330.21 (1) personal care assistance services as defined in section 256B.0625, subdivision 19a,
330.22 and provided according to section 256B.0659;

330.23 (2) community first services and supports under section 256B.85;

330.24 (3) home health services under section 256B.0625, subdivision 6a; or

330.25 (4) adult companion services;

330.26 (5) adult day services;

330.27 (6) adult rehabilitative mental health services;

330.28 (7) assertive community treatment;

330.29 (8) early intensive developmental and behavioral intervention;

331.1 (9) integrated community supports;

331.2 (10) nonemergency medical transportation services;

331.3 (11) recovery peer support;

331.4 (12) home and community-based services reimbursed at an hourly or specified

331.5 minute-based rate and provided according to a federally approved waiver plan as authorized

331.6 under chapter 256S or section 256B.0913, 256B.092, or 256B.49; or

331.7 (13) other medical supplies and equipment or home and community-based services that

331.8 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

331.9 (n) "State-provided electronic visit verification system" means the electronic visit

331.10 verification system made available by the commissioner to providers at no cost for services

331.11 subject to federal electronic visit verification requirements.

331.12 (o) "Third-party electronic visit verification system" means an electronic visit verification

331.13 system purchased or operated by a provider or vendor other than the state-provided system

331.14 designated by the commissioner.

331.15 (p) "Verification method" means the electronic process used to capture and verify visit

331.16 information, including telephone, fixed visit verification devices, or mobile applications,

331.17 as approved by the commissioner.

331.18 (q) "Visit" means a single occurrence of service delivery subject to electronic visit

331.19 verification.

331.20 (r) "Worker" means an individual who provides personal care assistance services,

331.21 community first services and supports, home health services, consumer-directed community

331.22 supports, or other services identified by the commissioner as subject to electronic visit.

331.23 Sec. 5. Minnesota Statutes 2024, section 256B.073, subdivision 3, is amended to read:

331.24 Subd. 3. **Requirements.** (a) ~~In developing implementation requirements for administering~~

331.25 ~~electronic visit verification, the commissioner shall~~ must ensure that the system and related

331.26 requirements:

331.27 (1) ~~are minimally administratively and financially burdensome to a provider~~ reasonable

331.28 for providers of services;

331.29 (2) ~~are minimally burdensome~~ support continued access to the services and are designed

331.30 to avoid disruption to service recipient and the least disruptive to the service recipient in

331.31 ~~receiving and maintaining allowed services~~ delivery or receipt;

332.1 (3) consider existing best practices and use of electronic visit verification;

332.2 (4) are conducted according to all state and federal laws;

332.3 (5) are effective methods for preventing fraud when balanced against the requirements
332.4 of clauses (1) and (2); and

332.5 (6) are consistent with the Department of Human Services' policies related to covered
332.6 services, flexibility of service use, and quality assurance.

332.7 (b) The commissioner ~~shall~~ must make training and guidance available to providers of
332.8 services on the electronic visit verification ~~system~~ requirements and system use.

332.9 (c) The commissioner ~~shall~~ must establish baseline measurements related to preventing
332.10 fraud and establish measures to determine the effect of electronic visit verification
332.11 requirements on program integrity.

332.12 (d) The commissioner ~~shall~~ must make a ~~state-selected~~ state-provided electronic visit
332.13 verification system available to providers of services.

332.14 (e) The commissioner ~~shall~~ must make available and publish on the agency website the
332.15 name and contact information for the vendor of the ~~state-selected~~ state-provided electronic
332.16 visit verification system and the other vendors that offer alternative electronic visit
332.17 verification systems. The information provided must state that the ~~state-selected~~
332.18 state-provided electronic visit verification system is offered at no cost to the provider of
332.19 services and that the provider of services may choose an alternative system that may be at
332.20 a cost to the provider.

332.21 (f) The commissioner may establish implementation dates and implementation schedules
332.22 for system functions subject to electronic visit verification under this section, including but
332.23 not limited to verification methods or technical requirements.

332.24 (g) The commissioner may waive the requirements under this section for any service
332.25 component or setting when the application of electronic visit verification is contrary to
332.26 paragraph (a).

332.27 Sec. 6. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
332.28 to read:

332.29 Subd. 4a. **Electronic visit verification system options.** (a) A provider of services must
332.30 use an electronic visit verification system that complies with the requirements established
332.31 by the commissioner. A provider of services may use either the state-provided system or a

333.1 third-party system. All systems used for compliance must provide data to the commissioner
333.2 in the format and with the frequency required by the commissioner.

333.3 (b) The commissioner must make a state-provided electronic visit verification system
333.4 available at no cost to providers of services. The commissioner must provide training on
333.5 the system to all providers of services.

333.6 (c) The commissioner must allow providers of services to utilize a third-party electronic
333.7 visit verification system that the commissioner determines meets the requirements under
333.8 this section.

333.9 (d) A provider of services using a third-party electronic visit verification system that
333.10 meets all technical specifications and federal and state laws must:

333.11 (1) collect and submit all data for each visit to the commissioner, including but not
333.12 limited to manual entries;

333.13 (2) maintain compliance identified by the commissioner, including but not limited to
333.14 incorporating into the system any changes in data requirements that must be transmitted to
333.15 the commissioner; and

333.16 (3) integrate the system with the data aggregator to accurately send data.

333.17 (e) The data aggregator must be available at no cost to a provider of services for purposes
333.18 of transmitting electronic visit verification data from approved third-party systems to the
333.19 commissioner. Any costs associated with the development and use of a third-party system
333.20 are the responsibility of the provider.

333.21 (f) If a provider is unable to integrate a third-party system with the data aggregator, the
333.22 provider of services must use the state-provided electronic visit verification system.

333.23 (g) The commissioner must provide training on reviewing and correcting imported data
333.24 in the data aggregator to providers of services.

333.25 Sec. 7. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
333.26 to read:

333.27 Subd. 4b. **Provider responsibilities.** A provider of services must:

333.28 (1) use an electronic visit verification system that meets all technical and data submission
333.29 requirements established by the commissioner;

333.30 (2) enroll with the state-provided electronic visit verification system or the data
333.31 aggregator, as applicable;

- 334.1 (3) provide all information requested by the commissioner for enrollment, access, and
334.2 data submission and ensure that the information remains accurate and up to date;
- 334.3 (4) maintain records for each individual receiving services subject to electronic visit
334.4 verification, including but not limited to all required data elements;
- 334.5 (5) maintain a current list of workers providing services subject to electronic visit
334.6 verification to individuals receiving services under medical assistance;
- 334.7 (6) provide the commissioner and any managed care organization with immediate, direct,
334.8 and on-site or remote access to the electronic visit verification system;
- 334.9 (7) at the request of the commissioner or a managed care organization, allow review or
334.10 copying of electronic visit verification documentation at no cost;
- 334.11 (8) ensure that electronic visit verification systems and related processes meet accessibility
334.12 and confidentiality requirements under state and federal law;
- 334.13 (9) comply with all policies, procedures, and technical specifications issued by the
334.14 commissioner under this section; and
- 334.15 (10) ensure that workers, participants, and other individuals using electronic visit
334.16 verification are trained and comply with all documentation and data entry requirements
334.17 established by the commissioner.

334.18 Sec. 8. Minnesota Statutes 2024, section 256B.073, subdivision 5, is amended to read:

334.19 Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system
334.20 ~~selected~~ provided by the commissioner and the vendor's affiliate must comply with the
334.21 requirements of this subdivision.

334.22 (b) The vendor of the ~~state-selected~~ state-provided electronic visit verification system
334.23 and the vendor's affiliate must:

334.24 (1) notify the provider of services that the provider may choose the ~~state-selected~~
334.25 state-provided electronic visit verification system at no cost to the provider;

334.26 (2) offer the ~~state-selected~~ state-provided electronic visit verification system to the
334.27 provider of services prior to offering any fee-based electronic visit verification system;

334.28 (3) notify the provider of services that the provider may choose any fee-based electronic
334.29 visit verification system prior to offering the vendor's or its affiliate's fee-based electronic
334.30 visit verification system; and

(4) when offering the ~~state-selected~~ state-provided electronic visit verification system, clearly differentiate between the ~~state-selected~~ state-provided electronic visit verification system and the vendor's or its affiliate's alternative fee-based system.

(c) The vendor of the ~~state-selected~~ state-provided electronic visit verification system and the vendor's affiliate must not use state data that are not available to other vendors of electronic visit verification systems to promote or sell the vendor's or its affiliate's alternative electronic visit verification system.

(d) Upon request from the provider, the vendor of the ~~state-selected~~ state-provided electronic visit verification system must provide proof of compliance with the requirements of paragraph (b).

(e) An agreement between the vendor of the ~~state-selected~~ state-provided electronic visit verification system or its affiliate and a provider of services for an electronic visit verification system that is not the ~~state-selected~~ state-provided system entered into on or after July 1, 2023, is subject to immediate termination by the provider if the vendor violates any of the requirements of paragraph (b).

Sec. 9. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 6. Data and documentation. (a) A provider of services must submit electronic visit verification data to the commissioner or the data aggregator in accordance with the technical standards, format, and frequency established under this section. The commissioner may use integrated electronic visit verification data for oversight, quality assurance, and program integrity purposes consistent with state and federal law.

(b) The commissioner and managed care organizations must use electronic visit verification data to validate claims for payment under medical assistance. Claims that cannot be validated in accordance with electronic visit verification requirements may be subject to actions by the commissioner as authorized under state and federal law, including actions related to payment, program integrity, or provider compliance.

(c) A provider of services must record all required electronic visit verification data at the time of service delivery using an approved verification method. To be compliant with electronic visit verification requirements, a provider of services must document a visit with all required data elements recorded at the time of service delivery.

(d) A manual visit does not comply with electronic visit verification requirements. A manual visit must be confirmed and verified according to processes established by the commissioner before being used to validate or support a claim for payment.

(e) A worker providing services subject to electronic visit verification must record the start and end times of each visit at the time the service is delivered using an approved verification method. A worker must complete and verify all time documentation, including but not limited to verification of service type, date, and duration, on the date the service occurs and be consistent with documentation requirements of the service being provided. A provider of services must maintain documentation demonstrating compliance with this subdivision and make the documentation available to the commissioner or a managed care organization upon request.

Sec. 10. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 7. **Third-party system responsibilities.** (a) This subdivision is effective for Early Intensive Developmental and Behavioral Intervention services beginning July 1, 2027, or upon federal approval, whichever is later. This subdivision is effective for all other services subject to this subdivision beginning January 1, 2027, or upon federal approval, whichever is later.

(b) A provider of services using a third-party electronic visit verification system must ensure that the system meets all technical, functional, and data-exchange requirements established by the commissioner and transmits data to the commissioner or the data aggregator in the format and with the frequency required by the commissioner.

(c) A third-party electronic visit verification vendor must:

(1) comply with all technical, contractual, privacy, and security standards established by the commissioner;

(2) not use or disclose state data for any purpose other than fulfilling the requirements under this section or federal law;

(3) provide the commissioner access to system documentation, data mapping, and audit records upon request; and

(4) immediately report to the commissioner any data transmission failure, breach, or interruption affecting the commissioner's ability to receive required electronic visit verification data.

337.1 (d) A provider of services remains responsible for ensuring compliance with this section
337.2 even when using a third-party electronic visit verification system.

337.3 (e) The third-party vendor must ensure training on the system is available to providers
337.4 of services.

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

337.6 Sec. 11. **ELECTRONIC VISIT VERIFICATION AND MEDICAL ASSISTANCE**
337.7 **CLAIMS VALIDATION.**

337.8 (a) The commissioner of human services must develop, test, and implement systems
337.9 changes necessary to integrate data collected through electronic visit verification systems,
337.10 as described under Minnesota Statutes, section 256B.073, with Minnesota's Medicaid
337.11 Management Information System. Data collected through electronic visit verification systems
337.12 must be used as part of the commissioner's processes for validating claims for services
337.13 subject to electronic visit verification.

337.14 (b) The commissioner of human services must require that managed care plans and
337.15 county-based purchasing plans ensure electronic visit verification and claims system
337.16 interoperability by January 1, 2027.

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

337.18 Sec. 12. **REPEALER.**

337.19 Minnesota Statutes 2024, section 256B.073, subdivision 4, is repealed.

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

337.21 **ARTICLE 11**

337.22 **MISCELLANEOUS**

337.23 Section 1. Minnesota Statutes 2024, section 142E.16, is amended by adding a subdivision
337.24 to read:

337.25 Subd. 1a. **Training required for payments.** (a) As a condition of payment and prior to
337.26 authorization, all providers receiving child care assistance payments must complete
337.27 compliance training developed by the commissioner that addresses program integrity
337.28 requirements including but not limited to record keeping and billing requirements. The
337.29 commissioner shall develop criteria, reporting requirements, and standards for when providers
337.30 need to renew training after their initial registration.

(b) Providers that do not have an active registration to receive child care assistance on or before April 10, 2028, must complete the training under this subdivision prior to authorization. Providers with an active registration on or before April 10, 2028, must complete the training under this subdivision before the provider's first renewal after April 10, 2028, or April 9, 2029, whichever is later.

Sec. 2. Minnesota Statutes 2024, section 245.096, is amended to read:

245.096 CHANGES TO GRANT PROGRAMS.

Prior to implementing any ~~substantial~~ changes to a grant funding formula disbursed through allocations administered by the commissioner, the commissioner must provide a report on the nature of the changes, the effect the changes will have, whether any funding will change, and other relevant information, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. The report must be provided prior to the start of a regular session, and the proposed changes cannot be implemented until after the adjournment of that regular session.

Sec. 3. **DIRECTION TO COMMISSIONER; ASSESSMENT OF ADMINISTRATIVE ROLES.**

(a) The commissioners of human services and children, youth, and families, in consultation with Minnesota's Tribal Nations and counties, must conduct a study to assess and recommend improvements to the roles and responsibilities of the Departments of Human Services and Children, Youth, and Families, the counties, and Minnesota's Tribal Nations in administering human services programs.

(b) The study must include a comprehensive review of programs administered by the departments, including but not limited to medical assistance, MinnesotaCare, behavioral health services, long-term services and supports, housing and homelessness programs, Minnesota supplemental aid, general assistance, economic assistance, child support, child care and early learning, and licensing and oversight functions.

(c) The study must evaluate the:

(1) current roles and responsibilities held by the departments, the counties, and Minnesota's Tribal Nations in administering human services programs, including but not limited to the challenges and benefits of the current delegation of roles and responsibilities;

(2) lived experience of people accessing human services programs related to the delegation of administrative duties;

(3) financing of human services program administration across the departments, the counties, and Minnesota's Tribal Nations;

(4) variations in service delivery between different geographical regions of the state; and

(5) administration of human services programs in other states, focusing on the roles and responsibilities of the local governments versus the state Medicaid or human services agency, and identifying the benefits, challenges, and financing of the delegation of duties.

(d) The study must focus on the goals of transforming the human services system to ensure a transparent, accessible, accountable, equitable, and effective human services system.

(e) The study must provide recommendations for the optimal delegation of duties between the departments, the counties, and Minnesota's Tribal Nations in the delivery of human services. Recommendations must include:

(1) how the delegation of duties will improve the experience of people accessing human services;

(2) implementation and timing considerations to ensure continuity of services;

(3) systems technology adaptations required;

(4) workforce considerations; and

(5) financing strategies and the estimated fiscal impact to the state budget.

(f) Notwithstanding Minnesota Statutes, chapter 13, or other statutes or rules to the contrary, counties must provide financial, human resources, and other information necessary to complete the study in the form and manner and on the timeline requested by the commissioners.

(g) By October 1, 2028, the commissioners must submit a report on the study and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health; human services; and children, youth, and families policy and finance.

Sec. 4. **DIRECTION TO COMMISSIONER; TRANSFER ASSESSMENT.**

(a) The commissioner of human services must procure a contract with a vendor to assess the current status of administration of medical assistance and plan for a transfer of administration of medical assistance to the commissioner by January 1, 2033. The commissioner must submit the assessment and plan to the chairs and ranking minority

340.1 members of the legislative committees with jurisdiction over human services and health
340.2 care policy and finance by October 1, 2028.

340.3 (b) The assessment and plan must include:

340.4 (1) a comprehensive assessment of medical assistance eligibility functions performed
340.5 by counties and Tribal governments, including identification of handoffs between county
340.6 and Tribal eligibility workers and state eligibility workers, and a catalog of eligibility
340.7 functions performed by state eligibility workers;

340.8 (2) examination of current expenditures, administrative budgets, and federal financial
340.9 participation in county and Tribal administrative work related to medical assistance eligibility
340.10 activities;

340.11 (3) eligibility system review, mapping, and recommended updates; and

340.12 (4) recommendations for a successful transition of centralized eligibility functions based
340.13 on consultation with stakeholders, review of information provided by county and Tribal
340.14 governments, review of other states' best practices for maximizing federal dollars, a feasible
340.15 timeline of activities, and required legislative changes and actions.

340.16 (c) The commissioner must consult with Minnesota's Tribal Nations, the Association of
340.17 Minnesota Counties, and the Minnesota Association of County Social Service Administrators
340.18 on the final deliverables included in the assessment.

340.19 **Sec. 5. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
340.20 **EVALUATION OF DHS STRUCTURE AND PROCESSES.**

340.21 (a) The commissioner of human services must contract with an external consultant to
340.22 continue and complete the project initiated under Executive Order 25-10, section 1, paragraph
340.23 (g), to make recommendations to improve the Department of Human Services' performance
340.24 as the state's Medicaid agency. The external consultant must evaluate the department's
340.25 structure and processes and assess the adequacy of the department's current policies,
340.26 procedures, systems, organizational structure, staffing levels, and funding to effectively
340.27 increase program integrity, minimize fraud, and more effectively serve as the state's Medicaid
340.28 agency.

340.29 (b) Within 60 days of receiving the external consultant's recommendations, the
340.30 commissioner must submit a report to the chairs and ranking minority members of the
340.31 legislative committees with jurisdiction over health and human services policy and finance,
340.32 including information on the recommendations of the external consultant and any actions
340.33 the commissioner has taken in response to the external consultant's recommendations or

341.1 other actions taken by the commissioner pursuant to Executive Order 25-10, section 1,
341.2 paragraph (g).

341.3 (c) Within 60 days of receiving the external consultant's recommendations, the
341.4 commissioner must submit a summary of the recommendations of the external consultant
341.5 with whom the commissioner contracted under Executive Order 25-10, section 1, paragraph
341.6 (g), and any actions the commissioner has taken in response to either the external consultant's
341.7 recommendations or other actions taken by the commissioner pursuant to Executive Order
341.8 25-10, section 1, paragraph (g). The summary must be submitted to the chairs and ranking
341.9 minority members of the legislative committees with jurisdiction over health and human
341.10 services policy and finance.

341.11 (d) Within 60 days of receiving the external consultant's recommendations, the
341.12 commissioner must submit the external consultant's report summarizing the evaluation and
341.13 recommendations to the chairs and ranking minority members of the legislative committees
341.14 with jurisdiction over health and human services policy and finance. The commissioner
341.15 must also submit draft legislative language to implement the recommendations of the external
341.16 consultant's recommendations.

341.17 **Sec. 6. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
341.18 **CODIFYING THE OFFICE OF INSPECTOR GENERAL.**

341.19 (a) By December 1, 2026, the commissioner of human services must provide statutory
341.20 language that codifies the Department of Human Services Office of Inspector General to
341.21 the chairs and ranking minority members of the legislative committees with jurisdiction
341.22 over human services and the nonpartisan staff from House Research Department and Senate
341.23 Counsel, Research, and Fiscal Analysis whose drafting areas include human services. The
341.24 statutory language must only contain:

341.25 (1) existing legal authority identified by the office that the office relies upon to carry
341.26 out its duties; and

341.27 (2) policies and procedures necessary for the office to carry out its existing duties.

341.28 (b) The commissioner must not include desired policy changes to the office, its structure,
341.29 or its duties within the codification language required under paragraph (a).

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

ARTICLE 12

DHS APPROPRIATIONS

Section 1. HUMAN SERVICES APPROPRIATIONS.

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2025, First Special Session chapter 3, article 20, and Laws 2025, First Special Session chapter 9, article 12, to the agency and for purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2025, First Special Session chapter 3, article 20, and Laws 2025, First Special Session chapter 9, article 12. Appropriations and reductions to appropriations for the fiscal year ending June 30, 2026, are effective the day following final enactment unless a different effective date is explicit.

		<u>APPROPRIATIONS</u>	
		<u>Available for the Year</u>	
		<u>Ending June 30</u>	
		<u>2026</u>	<u>2027</u>
Sec. 2. <u>TOTAL APPROPRIATION</u>	\$	<u>(10,098,000)</u>	\$ <u>(50,711,000)</u>
Sec. 3. <u>CENTRAL OFFICE; OPERATIONS</u>	\$	<u>-0-</u>	\$ <u>27,743,000</u>

Subdivision 1. Evaluation of DHS Structure and Processes

\$500,000 in fiscal year 2027 is for a comprehensive evaluation of the Department of Human Services structure and processes.

This is a onetime appropriation and is available until June 30, 2028.

Subd. 2. Assessment of State, County, and Tribal Nation Roles in Administering Human Services Programs

\$3,000,000 in fiscal year 2027 is for an assessment of state, county, and Tribal Nation roles in administering human services programs. This is a onetime appropriation and is available until June 30, 2029.

343.1 **Subd. 3. Prepayment Review Vendor Contract**

343.2 \$2,500,000 in fiscal year 2027 is to conduct
343.3 ongoing prepayment claims analysis
343.4 technology for services provided under
343.5 medical assistance. This is a onetime
343.6 appropriation.

343.7 **Subd. 4. Prepayment Review Technology**
343.8 **Contract**

343.9 \$4,000,000 in fiscal year 2027 is for a
343.10 competitively awarded vendor contract to
343.11 support prepayment review technology to
343.12 build on and reference existing claims edits
343.13 infrastructure, prior authorization criteria, and
343.14 continuous refining of the prepayment review
343.15 analytic module to automate fraud detection
343.16 and payment integrity based on findings over
343.17 time.

343.18 **Subd. 5. Base Level Adjustment**

343.19 The general fund base is increased by
343.20 \$22,617,000 in fiscal year 2028 and increased
343.21 by \$20,320,000 in fiscal year 2029.

343.22 **Sec. 4. CENTRAL OFFICE; HEALTH CARE** **\$** **-0-** **\$** **4,169,000**

343.23 **Subdivision 1. Medical Assistance Eligibility**
343.24 **Study**

343.25 \$2,000,000 in fiscal year 2027 is for a study
343.26 on the transfer of eligibility functions of the
343.27 medical assistance program performed by
343.28 county and Tribal governments to the
343.29 Department of Human Services. This is a
343.30 onetime appropriation and is available until
343.31 June 30, 2029.

344.1 Subd. 2. **Base Level Adjustment**344.2 The general fund base is increased by344.3 \$2,627,000 in fiscal year 2028 and increased344.4 by \$3,782,000 in fiscal year 2029.344.5 Sec. 5. **CENTRAL OFFICE; AGING AND**
344.6 **DISABILITY SERVICES**

\$ (3,745,000) \$ 19,404,000

344.7 Subdivision 1. **Market Rate and Homemaker**
344.8 **Services Rate Study**344.9 \$500,000 in fiscal year 2027 is for a study on344.10 rate setting methodologies for services344.11 currently offered under market rate344.12 methodologies and homemaker services. This344.13 is onetime appropriation and is available until344.14 June 30, 2028.344.15 Subd. 2. **MnCHOICES Redesign Working**
344.16 **Group**344.17 \$450,000 in fiscal year 2027 is for a contract344.18 related to the MnCHOICES redesign working344.19 group. The base for this appropriation is344.20 \$500,000 in fiscal year 2028, \$250,000 in344.21 fiscal year 2029, \$0 in fiscal year 2030, and344.22 \$0 in fiscal year 2031.344.23 Subd. 3. **Waiver Case Management Advisory**
344.24 **Working Group**344.25 \$350,000 in fiscal year 2027 is for a contract344.26 related to the waiver case management344.27 advisory working group. The base for this344.28 appropriation is \$150,000 in fiscal year 2028344.29 and \$0 in fiscal year 2029.344.30 Subd. 4. **HCBS Waiver Case Management**
344.31 **Evaluation and Report**344.32 \$200,000 in fiscal year 2027 is for a rates344.33 study for case management and home and344.34 community-based services. This is a onetime344.35 appropriation and is available until June 30,

345.1 2028. The base for this appropriation is
345.2 \$400,000 in fiscal year 2028 and \$0 in fiscal
345.3 year 2029.

345.4 Subd. 5. **Nursing Facility Workforce Wage**
345.5 **Supplement Program**

345.6 \$3,000,000 in fiscal year 2027 is for a contract
345.7 to administer the nursing facility workforce
345.8 wage supplement program under Minnesota
345.9 Statutes, section 256R.60. This is a onetime
345.10 appropriation and is available until June 30,
345.11 2028.

345.12 Subd. 6. **Integrated Community Supports**
345.13 **Reform Study**

345.14 \$300,000 in fiscal year 2027 is for an
345.15 integrated community supports reform study.
345.16 This is a onetime appropriation and is
345.17 available until June 30, 2028.

345.18 Subd. 7. **Base Level Adjustment**

345.19 The general fund base is increased by
345.20 \$24,811,000 in fiscal year 2028 and increased
345.21 by \$32,767,000 in fiscal year 2029.

345.22	<u>Sec. 6. CENTRAL OFFICE; BEHAVIORAL</u>			
345.23	<u>HEALTH</u>	<u>\$</u>	<u>-0-</u>	<u>\$ 2,382,000</u>

345.24 Subdivision 1. **Access to Services for**
345.25 **Incarcerated Individuals Evaluation**

345.26 \$150,000 in fiscal year 2027 is for community
345.27 engagement and evaluation related reentry
345.28 services.

345.29 Subd. 2. **Base Level Adjustment**

345.30 The general fund base is increased by
345.31 \$2,974,000 in fiscal year 2028 and increased
345.32 by \$2,957,000 in fiscal year 2029.

345.33	<u>Sec. 7. CENTRAL OFFICE; OFFICE OF</u>			
345.34	<u>INSPECTOR GENERAL</u>	<u>\$</u>	<u>-0-</u>	<u>\$ 16,328,000</u>

346.1 Subdivision 1. **Postpayment Review of Managed**
346.2 **Care Organization Billing**

346.3 The base must include \$30,000,000 in fiscal
346.4 year 2028 and \$30,000,000 in fiscal year 2029
346.5 for a competitively awarded vendor contract
346.6 to support postpayment review of managed
346.7 care organization billing.

346.8 Subd. 2. **Base Level Adjustment**

346.9 The general fund base is increased by
346.10 \$49,482,000 in fiscal year 2028 and increased
346.11 by \$49,333,000 in fiscal year 2029. The
346.12 special revenue government fund base is
346.13 increased by \$1,426,000 in fiscal year 2028
346.14 and increased by \$2,352,000 in fiscal year
346.15 2029.

346.16	<u>Sec. 8. FORECASTED PROGRAMS;</u>			
346.17	<u>HOUSING SUPPORT</u>	<u>\$</u>	<u>-0-</u>	<u>\$ 12,524,000</u>

346.18	<u>Sec. 9. FORECASTED PROGRAMS;</u>			
346.19	<u>MEDICAL ASSISTANCE</u>	<u>\$</u>	<u>-0-</u>	<u>\$ (122,888,000)</u>

346.20	<u>Sec. 10. FORECASTED PROGRAMS;</u>			
346.21	<u>ALTERNATIVE CARE</u>	<u>\$</u>	<u>-0-</u>	<u>\$ (213,000)</u>

346.22	<u>Sec. 11. FORECASTED PROGRAMS;</u>			
346.23	<u>BEHAVIORAL HEALTH FUND</u>	<u>\$</u>	<u>-0-</u>	<u>\$ (19,248,000)</u>

346.24	<u>Sec. 12. GRANT PROGRAM; OTHER</u>			
346.25	<u>LONG-TERM CARE GRANTS</u>	<u>\$</u>	<u>(972,000)</u>	<u>\$ 7,683,000</u>

346.26 Subdivision 1. **Nursing Facility Workforce Wage**
346.27 **Supplement Program**

346.28 \$9,508,000 in fiscal year 2027 is for the
346.29 nursing facility workforce wage supplement
346.30 program under Minnesota Statutes, section
346.31 256R.60. This is a onetime appropriation and
346.32 is available until June 30, 2028.

347.1 Subd. 2. **Linguistically and Culturally Specific**
347.2 **Training**

347.3 \$250,000 in fiscal year 2027 is for a grant to
347.4 Isuroon to support its mission to provide: (1)
347.5 linguistically and culturally specific services
347.6 and in-person training to bilingual individuals,
347.7 particularly bilingual women from diverse
347.8 ethnic backgrounds, to navigate health care
347.9 systems, to advocate for their well-being when
347.10 accessing health care, to develop financial
347.11 literacy, to increase civic engagement, and to
347.12 develop leadership skills; and (2) technical
347.13 assistance to health care providers through
347.14 training, resources, and ongoing support. The
347.15 base for this appropriation is \$500,000 in fiscal
347.16 year 2028 and \$500,000 in fiscal year 2029.

347.17 Subd. 3. **Base Level Adjustment**

347.18 The general fund base is decreased by
347.19 \$1,425,000 in fiscal year 2028 and decreased
347.20 by \$1,425,000 in fiscal year 2029.

347.21 Sec. 13. **GRANT PROGRAM; AGING AND**
347.22 **ADULT SERVICES GRANTS**

\$ (477,000) \$ -0-

347.23 Sec. 14. **GRANT PROGRAM; DISABILITIES**
347.24 **GRANTS**

\$ (2,256,000) \$ (145,000)

347.25 **Base Level Adjustment.** The general fund
347.26 base is decreased by \$956,000 in fiscal year
347.27 2028 and decreased by \$956,000 in fiscal year
347.28 2029.

347.29 Sec. 15. **GRANT PROGRAMS; HOUSING**
347.30 **GRANTS**

\$ (1,112,000) \$ 1,250,000

347.31 Subdivision 1. **Housing Support**
347.32 **Capacity-Building Grants**

347.33 \$1,250,000 in fiscal year 2027 is for housing
347.34 support capacity-building grants. This is a

348.1 onetime appropriation and is available until
 348.2 June 30, 2028.

348.3 **Subd. 2. Base Level Adjustment**

348.4 The general fund base for this appropriation
 348.5 is \$0 in fiscal year 2028 and \$0 in fiscal year
 348.6 2029.

348.7	<u>Sec. 16. GRANT PROGRAMS; ADULT</u>			
348.8	<u>MENTAL HEALTH GRANTS</u>	<u>\$</u>	<u>(20,000)</u>	<u>\$ -0-</u>

348.9	<u>Sec. 17. GRANT PROGRAMS; CHILD</u>			
348.10	<u>MENTAL HEALTH GRANTS</u>	<u>\$</u>	<u>(1,516,000)</u>	<u>\$ -0-</u>

348.11	<u>Sec. 18. GRANT PROGRAMS; SUBSTANCE</u>			
348.12	<u>USE DISORDER GRANTS</u>	<u>\$</u>	<u>-0-</u>	<u>\$ 300,000</u>

348.13 Subdivision 1. Todd County; Peer Recovery
 348.14 Support

348.15 \$300,000 in fiscal year 2027 is for a grant to
 348.16 Todd County for a contract with an
 348.17 organization operating in Todd County to
 348.18 provide daily peer recovery support services
 348.19 and special sessions for individuals who are
 348.20 in substance use recovery, are transitioning
 348.21 out of incarceration, or have experienced
 348.22 trauma.

348.23 **Subd. 2. Thrive Family Recovery Resources**

348.24 \$200,000 in fiscal year 2027 is for a grant to
 348.25 Thrive Family Recovery Resources for a pilot
 348.26 program that provides family peer services,
 348.27 education, resource navigation, and general
 348.28 support for families impacted by substance
 348.29 use disorder. By January 20, 2028, the
 348.30 commissioner must submit a report to the
 348.31 chairs and ranking minority members of the
 348.32 legislative committees with jurisdiction over
 348.33 human services that evaluates the results of
 348.34 the pilot program and makes recommendations
 348.35 for developing an ongoing grant program to

349.1 provide supportive services and education for
349.2 families impacted by substance use disorder.
349.3 This is a onetime appropriation.

349.4 Sec. 19. Laws 2025, First Special Session chapter 3, article 20, section 19, subdivision 1,
349.5 is amended to read:

349.6 Subdivision 1. **Intensive Residential Treatment**
349.7 **Services Community Health Unit; Hennepin**
349.8 **County**

349.9 \$563,000 in fiscal year 2026 is for a grant to
349.10 the city of Brooklyn Park ~~as start-up funding~~
349.11 ~~for an intensive residential treatment services~~
349.12 ~~and residential crisis stabilization services~~
349.13 ~~facility~~ for the city of Brooklyn Park's
349.14 Community Health Unit, operating out of the
349.15 Brooklyn Park Police Department. This is a
349.16 onetime appropriation and is available until
349.17 June 30, ~~2027~~ 2028.

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

349.19 Sec. 20. Laws 2025, First Special Session chapter 3, article 21, section 3, subdivision 2,
349.20 is amended to read:

349.21 Subd. 2. **Substance Use Treatment, Recovery,**
349.22 **and Prevention Grants**

349.23 \$3,000,000 in fiscal year 2026 and \$3,000,000
349.24 in fiscal year 2027 are from the general fund
349.25 for substance use treatment, recovery, and
349.26 prevention grants under Minnesota Statutes,
349.27 section 342.72. The commissioner may use
349.28 up to \$300,000 of this appropriation for
349.29 administration.

349.30 Sec. 21. **TRANSFERS AND CANCELLATIONS.**

349.31 Subdivision 1. **MnCHOICES modification grants.** The fiscal year 2027 general fund
349.32 base appropriation for MnCHOICES modifications first established under Laws 2023,

chapter 61, article 9, section 2, subdivision 16, is reduced from \$125,000 to \$0. The general fund base for this purpose is \$0 in fiscal year 2028 and \$0 in fiscal year 2029.

Subd. 2. Day training and habilitation facility grants. The fiscal year 2028 and fiscal year 2029 general fund base for grant allocations to counties for day training and habilitation services for adults with developmental disabilities when provided as a social service under Minnesota Statutes, sections 252.41 to 252.46, are reduced from \$811,000 to \$0.

Subd. 3. Innovation grants. The fiscal year 2027 general fund base appropriation for the innovation grants program under Minnesota Statutes, section 256B.0921, is reduced from \$1,925,000 to \$0. The general fund base for this purpose is \$0 in fiscal year 2028 and \$0 in fiscal year 2029.

Subd. 4. Preadmission screening grant program. The fiscal year 2027 general fund base appropriation for the preadmission screening grant program under Minnesota Statutes, section 256.975, subdivision 7d, paragraph (b), is reduced from \$20,000 to \$0. The general fund base for this purpose is \$0 in fiscal year 2028 and \$0 in fiscal year 2029.

Subd. 5. 2023 Long-term services and supports loan program. (a) \$65,234,000 in fiscal year 2026 from the long-term services and supports loan program under Minnesota Statutes, section 256.4792, subdivision 8a, is transferred from the long-term services and supports loan account in the special revenue fund to the general fund and is canceled.

(b) Any unencumbered and unexpended amount of the long-term services and supports loan program under Minnesota Statutes, section 256.4792, subdivision 8a, estimated to be \$5,620,000, is transferred from the long-term services and supports loan account in the special revenue fund to the general fund and is canceled in fiscal year 2028.

Subd. 6. 2024 Long-term services and supports loan program. Any unencumbered and unexpended amount of the fiscal year 2026 general fund base appropriation for the long-term services and supports loan program first established under Laws 2024, chapter 125, article 8, section 2, subdivision 12, paragraph (e), estimated to be \$822,000, is canceled.

Subd. 7. Long-term services and supports loan program administrative funding. Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 5, paragraph (g), clause (3), for administration of the long-term services and supports loan program under Minnesota Statutes, section 256.4792, estimated to be \$8,433,000, is transferred from the long-term services and supports loan account in the special revenue fund to the general fund and is canceled.

351.1 Subd. 8. **Motion analysis advancements clinical study and patient care.** Any
351.2 unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023,
351.3 chapter 61, article 9, section 2, subdivision 16, paragraph (l), for the motion analysis
351.4 advancement clinical study and patient care grant, estimated to be \$97,000, is canceled.

351.5 Subd. 9. **Aging and disability services for immigrant and refugee communities.** Any
351.6 unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024,
351.7 chapter 125, article 8, section 2, subdivision 14, paragraph (h), for the aging and disability
351.8 services for immigrant and refugee communities grant, estimated to be \$250,000, is canceled.

351.9 Subd. 10. **Health awareness hub pilot project.** (a) Any unencumbered and unexpended
351.10 amount of the fiscal year 2026 appropriation in Laws 2025, First Special Session chapter
351.11 9, article 12, section 15, subdivision 1, for the health awareness hub pilot project grant,
351.12 estimated to be \$150,000, is canceled.

351.13 (b) Any unencumbered and unexpended amount of the fiscal year 2027 appropriation
351.14 in Laws 2025, First Special Session chapter 9, article 12, section 15, subdivision 1, for the
351.15 health awareness hub pilot project grant, estimated to be \$150,000, is canceled.

351.16 Subd. 11. **Own home services provider capacity-building.** The amount of the fiscal
351.17 year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 14,
351.18 paragraph (j), for the own home services provider capacity-building grant, is reduced by
351.19 \$288,000.

351.20 Subd. 12. **License transition support for small disability waiver providers.** Any
351.21 unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024,
351.22 chapter 125, article 8, section 2, subdivision 14, paragraph (i), for the license transition
351.23 support for small disability waiver providers grant, estimated to be \$1,262,000, is canceled.

351.24 Subd. 13. **Parent-to-parent programs.** Any unencumbered and unexpended amount
351.25 of the fiscal year 2025 appropriation in Laws 2023, chapter 61, article 9, section 2,
351.26 subdivision 16, paragraph (n), for the parent-to-parent programs grant, estimated to be
351.27 \$109,000, is canceled.

351.28 Subd. 14. **Dakota County disability services workforce shortage pilot project.** Any
351.29 unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024,
351.30 chapter 125, article 8, section 2, subdivision 14, paragraph (b), for the Dakota County
351.31 disability services workforce shortage pilot project grant, estimated to be \$250,000, is
351.32 canceled.

352.1 Subd. 15. **Disability services person-centered engagement and navigation study.** Any
352.2 unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024,
352.3 chapter 125, article 8, section 2, subdivision 4, paragraph (b), for the disability services
352.4 person-centered engagement and navigation study, estimated to be \$438,000, is canceled.

352.5 Subd. 16. **Reimbursement for community-first services and supports workers**
352.6 **report.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation
352.7 in Laws 2024, chapter 125, article 8, section 2, subdivision 4, paragraph (d), for the
352.8 reimbursement for community-first services and supports workers report, estimated to be
352.9 \$99,000, is canceled.

352.10 Subd. 17. **Aging and disability services administration.** The amount of the fiscal year
352.11 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 5, paragraph
352.12 (g), clause (1), for general administrative purposes for the aging and disability services
352.13 administration, is reduced by \$1,797,000.

352.14 Subd. 18. **Aging and disability services administration carryforward.** The amount
352.15 of the fiscal year 2025 carryforward authorization in Laws 2024, chapter 125, article 8,
352.16 section 2, subdivision 4, paragraph (e), for aging and disability services administration, is
352.17 reduced by \$1,411,000. Of this reduced amount, \$1,083,000 is from the presumptive
352.18 eligibility study, \$200,000 is from administration of license transition support for small
352.19 disability waiver providers, and \$128,000 is from administration of the Dakota County
352.20 disability services workforce shortage pilot project.

352.21 Subd. 19. **Aging and adult services.** The fiscal year 2026 general fund base appropriation
352.22 in Laws 2025, First Special Session chapter 9, article 12, section 16, for aging and adult
352.23 services grants is reduced by \$477,000.

352.24 Subd. 20. **Youth peer recovery support services pilot project.** Any unencumbered
352.25 and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125,
352.26 article 8, section 2, subdivision 16, for the youth peer recovery support services pilot project,
352.27 estimated to be \$250,000, is canceled.

352.28 Subd. 21. **Child mental health.** The fiscal year 2026 general fund base appropriation
352.29 in Laws 2025, First Special Session chapter 3, article 20, section 20, for child mental health
352.30 grants is reduced by \$266,000.

352.31 Subd. 22. **Psychiatric residential treatment facility start-up.** Any unencumbered and
352.32 unexpended amount of the fiscal year 2024 and fiscal year 2025 appropriations in Laws
352.33 2023, chapter 70, article 20, section 2, subdivision 30, paragraph (a), for the psychiatric
352.34 residential treatment facility start-up grant, estimated to be \$1,000,000, are canceled.

353.1 Subd. 23. **Mental health innovation grant program.** Any unencumbered and
353.2 unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article
353.3 8, section 2, subdivision 15, paragraph (c), for the mental health innovation grant program,
353.4 estimated to be \$20,000, is canceled.

353.5 Subd. 24. **Housing and support services.** The amount of the fiscal year 2026 general
353.6 fund base appropriation in Laws 2025, First Special Session chapter 3, article 20, section
353.7 18, for housing and support services grants, is reduced by \$1,112,000. Of this reduced
353.8 amount:

353.9 (1) \$250,000 is from transition housing program grants;

353.10 (2) \$160,000 is from emergency services program grants;

353.11 (3) \$495,000 is from Homeless Youth Act grants;

353.12 (4) \$140,000 is from safe harbor grants; and

353.13 (5) \$67,000 is from shelter-linked mental health grants.

353.14 Subd. 25. **Recovery community organization.** Any unencumbered and unexpended
353.15 amount for the recovery community organization grants first established under Laws 2023,
353.16 chapter 61, article 9, section 2, subdivision 10, paragraph (h), estimated to be \$200,000, is
353.17 canceled.

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

353.19 Sec. 22. **APPROPRIATIONS GIVEN EFFECT ONCE.**

353.20 If an appropriation, transfer, or cancellation in this article is enacted more than once
353.21 during the 2026 regular session, the appropriation, transfer, or cancellation must be given
353.22 effect once.

353.23 Sec. 23. **EXPIRATION OF UNCODIFIED LANGUAGE.**

353.24 All uncoded language contained in this article expires on June 30, 2027, unless a
353.25 different expiration date is explicit.

353.26 **ARTICLE 13**

353.27 **OTHER AGENCY APPROPRIATIONS**

353.28 Section 1. **OTHER AGENCY APPROPRIATIONS.**

353.29 The sums shown in the columns marked "Appropriations" are added to or, if shown in
353.30 parentheses, are subtracted from the appropriations in Laws 2025, First Special Session

chapter 9, article 14, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the addition or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2025, First Special Session chapter 9, article 14. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2026, are effective the day following final enactment unless a different effective date is explicit.

				APPROPRIATIONS Available for the Year Ending June 30 20262027
Sec. 2. COMMISSIONER OF HEALTH;				
TOTAL APPROPRIATION	\$	-0-	\$	805,000
The amounts that may be spent for each				
purpose are specified in the following sections.				
Sec. 3. HEALTH PROTECTION	\$	-0-	\$	805,000
Subdivision 1. Small Assisted Living Facility				
Licensure				
\$150,000 in fiscal year 2027 is for the				
commissioner of health to develop small				
assisted living facility licensure draft				
legislation. This is a onetime appropriation				
and is available until June 30, 2028.				
Subd. 2. Base Level Adjustment				
The general fund base is increased by				
\$630,000 in fiscal year 2028 and \$630,000 in				
fiscal year 2029.				
Sec. 4. COMMISSIONER OF CHILDREN,				
YOUTH, AND FAMILIES	\$	-0-	\$	5,924,000
Subdivision 1. Operations and Administration;				
Agency-Wide Supports		-0-		5,777,000
(a) Analysis of Governance Roles for DCYF				
Programs. \$2,500,000 in fiscal year 2027 is				

355.1 for a study to analyze the governance roles for
355.2 DCYF programs. This is a onetime
355.3 appropriation and is available until June 30,
355.4 2029.

355.5 (b) **Base Level Adjustment.** The general fund
355.6 base is increased by \$3,226,000 in fiscal year
355.7 2028 and \$3,013,000 in fiscal year 2029.

355.8 Subd. 2. **Operations and Administration; Early**
355.9 **Childhood**

-0-

147,000

355.10 **Base Level Adjustment.** The general fund
355.11 base is increased by \$526,000 in fiscal year
355.12 2028 and \$687,000 in fiscal year 2029.

355.13 Subd. 3. **Grant Programs; Support Services**
355.14 **Grants**

-0-

-0-

355.15 **Fraud Prevention Investigation Grants.** The
355.16 base must include \$803,000 in fiscal year 2028
355.17 and \$803,000 in fiscal year 2029 for additional
355.18 fraud prevention investigation grants under
355.19 Minnesota Statutes, section 256.983.

355.20 Sec. 5. **COMMISSIONER OF EMPLOYMENT**
355.21 **AND ECONOMIC DEVELOPMENT**

\$

-0- \$

1,000,000

355.22 \$1,000,000 in fiscal year 2027 is for a grant
355.23 to Turning Point Inc., a 501(c)(3) nonprofit
355.24 organization, to predesign, design, construct,
355.25 renovate, furnish, and equip a 32-bed
355.26 residential facility to be known as "Ms. Bea's"
355.27 in the metropolitan area, as defined under
355.28 Minnesota Statutes, section 473.121,
355.29 subdivision 2. This appropriation includes
355.30 money for major projects to preserve or
355.31 replace mechanical, electrical, plumbing,
355.32 HVAC, and life safety systems; renovation
355.33 and construction of space for bedrooms, a
355.34 commercial kitchen, indoor recreation,
355.35 bathrooms, a workforce development and

356.1 resource room, and community common areas;
356.2 upgrades to achieve compliance with the
356.3 Americans with Disabilities Act (ADA); and
356.4 site improvements that prepare the space for
356.5 future expansion. This appropriation is
356.6 onetime and is available until the project is
356.7 completed or abandoned, subject to Minnesota
356.8 Statutes, section 16A.642.

356.9 Sec. 6. **RETURN OF UNUSED TAX-FORFEITED SETTLEMENT**
356.10 **APPROPRIATION; CANCELLATION.**

356.11 Subdivision 1. **Return of funds.** Notwithstanding the cancellation deadline established
356.12 in Laws 2024, chapter 113, section 1, subdivision 5, on June 29, 2026, the claims
356.13 administrator appointed under Laws 2024, chapter 113, to settle litigation related to the
356.14 state's retention of tax-forfeited lands, surplus proceeds from the sale of tax-forfeited lands,
356.15 and mineral rights in those lands, must return to the commissioner of management and
356.16 budget \$7,000,000 of the appropriation under Laws 2024, chapter 113, section 1, subdivision
356.17 5, that constitutes unspent money in the net settlement fund, as provided in the settlement
356.18 and final judgment filed on December 16, 2024.

356.19 Subd. 2. **Cancellation.** The commissioner of management and budget must cancel the
356.20 amount received under subdivision 1 to the general fund within one day of the receipt of
356.21 the money.

356.22 Subd. 3. **Application.** The money returned under subdivision 1 are in addition to any
356.23 other requirements enacted during the 2026 regular legislative session for the claims
356.24 administrator to return unspent money in the net settlement fund.

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

356.26 Sec. 7. **APPROPRIATIONS GIVEN EFFECT ONCE.**

356.27 If an appropriation, transfer, or cancellation in this article is enacted more than once
356.28 during the 2026 regular session, the appropriation, transfer, or cancellation must be given
356.29 effect once.

356.30 Sec. 8. **EXPIRATION OF UNCODIFIED LANGUAGE.**

356.31 All uncoded language contained in this article expires on June 30, 2027, unless a
356.32 different expiration date is explicit.

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Article locations for S4476-4

ARTICLE 1 CONTINUITY OF CARE..... Page.Ln 2.36

ARTICLE 2 LONG-TERM CARE FACILITY..... Page.Ln 11.18

ARTICLE 3 HEALTH CARE..... Page.Ln 19.7

ARTICLE 4 DEPARTMENT OF HUMAN SERVICES OIG POLICY..... Page.Ln 96.26

ARTICLE 5 BACKGROUND STUDIES..... Page.Ln 150.1

ARTICLE 6 BEHAVIORAL HEALTH..... Page.Ln 158.1

ARTICLE 7 UNIFORM SERVICE STANDARDS..... Page.Ln 176.14

ARTICLE 8 UNIFORM SERVICE STANDARDS CONFORMING CHANGES.... Page.Ln 242.18

ARTICLE 9 AGING AND DISABILITY SERVICES..... Page.Ln 255.19

ARTICLE 10 ELECTRONIC VISIT VERIFICATION..... Page.Ln 321.6

ARTICLE 11 MISCELLANEOUS..... Page.Ln 337.21

ARTICLE 12 DHS APPROPRIATIONS..... Page.Ln 342.1

ARTICLE 13 OTHER AGENCY APPROPRIATIONS..... Page.Ln 353.26

245.735 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES.

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

(b) "Alcohol and drug counselor" has the meaning given in section 245G.11, subdivision 5.

(c) "Care coordination" means the activities required to coordinate care across settings and providers for a person served to ensure seamless transitions across the full spectrum of health services. Care coordination includes outreach and engagement; documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan; assisting with obtaining appointments; confirming appointments are kept; developing a crisis plan; tracking medication; and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation with primary care practitioners and with mental health clinical care practitioners.

(d) "Community needs assessment" means an assessment to identify community needs and determine the community behavioral health clinic's capacity to address the needs of the population being served.

(e) "Comprehensive evaluation" means a person-centered, family-centered, and trauma-informed evaluation meeting the requirements of subdivision 4b completed for the purposes of diagnosis and treatment planning.

(f) "Designated collaborating organization" means an entity meeting the requirements of subdivision 3a with a formal agreement with a CCBHC to furnish CCBHC services.

(g) "Functional assessment" means an assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age and that meets the requirements of subdivision 4a.

(h) "Initial evaluation" means an evaluation completed by a mental health professional that gathers and documents information necessary to formulate a preliminary diagnosis and begin client services.

(i) "Integrated treatment plan" means a documented plan of care that is person- and family-centered and formulated to respond to a client's needs and goals.

(j) "Mental health professional" has the meaning given in section 245I.04, subdivision 2.

(k) "Mobile crisis services" has the meaning given in section 256B.0624, subdivision 2.

(l) "Preliminary screening and risk assessment" means a mandatory screening and risk assessment that is completed at the first contact with the prospective CCBHC service recipient and determines the acuity of client need.

Subd. 2a. **Establishment.** The certified community behavioral health clinic model is an integrated payment and service delivery model that uses evidence-based behavioral health practices to achieve better outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates for providers and economic efficiencies for payors.

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

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

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

(d) Entities that choose to be CCBHCs must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3a. **Designated collaborating organizations.** If a certified CCBHC is unable to provide one or more of the services listed in subdivision 3, paragraph (d), clauses (8) to (19), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the requirements of the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

Subd. 3b. **Exemptions to host county approval.** Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Subd. 3c. **Variances.** When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders before granting variances under this provision. For a CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Subd. 3d. **Evidence-based practices.** The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

Subd. 3e. **Recertification.** A CCBHC must apply for recertification every 36 months.

Subd. 3f. **Notice and opportunity for correction.** (a) The commissioner shall provide a formal written notice to an applicant for CCBHC certification outlining the determination of the application and process for applicable and necessary corrective action required of the applicant signed by the commissioner or appropriate division director to applicant entities within 45 calendar days of the site visit.

(b) The commissioner may reject an application if the applicant entity does not take all corrective actions specified in the notice and notify the commissioner that the applicant entity has done so within 60 calendar days.

(c) The commissioner must send the applicant entity a final decision on the corrected application within 45 calendar days of the applicant entity's notice to the commissioner that the applicant has taken the required corrective actions.

Subd. 3g. **Decertification process.** The commissioner must establish a process for decertification. The commissioner must require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application, certification, or recertification process.

Subd. 3h. **Minimum staffing standards.** A CCBHC must meet minimum staffing requirements required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

Subd. 4a. **Functional assessment requirements.** (a) For adults, a functional assessment may be completed using a Daily Living Activities-20 tool.

(b) Notwithstanding any law to the contrary, a functional assessment performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 256B.0623, subdivision 9;
- (2) section 245.4711, subdivision 3; and

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(3) Minnesota Rules, part 9520.0914, subpart 2.

Subd. 4b. **Requirements for comprehensive evaluations.** (a) A comprehensive evaluation must be completed for all new clients within 60 calendar days following the preliminary screening and risk assessment.

(b) Only a mental health professional may complete a comprehensive evaluation. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate.

(c) The comprehensive evaluation must consist of the synthesis of existing information including but not limited to an external diagnostic assessment, crisis assessment, preliminary screening and risk assessment, initial evaluation, and primary care screenings.

(d) A comprehensive evaluation must be completed in the cultural context of the client and updated to reflect changes in the client's conditions and at the client's request or when the client's condition no longer meets the existing diagnosis.

(e) The psychiatric evaluation and management service fulfills requirements for the comprehensive evaluation when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC shall complete the comprehensive evaluation within 60 calendar days of a client's referral for additional CCBHC services.

(f) For clients engaging exclusively in substance use disorder services at the CCBHC, a substance use disorder comprehensive assessment as defined in section 245G.05, subdivision 2, that is completed within 60 calendar days of service initiation shall fulfill requirements of the comprehensive evaluation.

(g) Notwithstanding any law to the contrary, a comprehensive evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 245.462, subdivision 20, paragraph (c);
- (2) section 245.4711, subdivision 2, paragraph (b);
- (3) section 245.4871, subdivision 6;
- (4) section 245.4881, subdivision 2, paragraph (c);
- (5) section 245G.04, subdivision 1;
- (6) section 245G.05, subdivision 1;
- (7) section 245I.10, subdivisions 4 to 6;
- (8) section 256B.0623, subdivisions 3, clause (4), 8, and 10;
- (9) section 256B.0943, subdivisions 3 and 6, paragraph (b), clause (1);
- (10) Minnesota Rules, part 9520.0909, subpart 1;
- (11) Minnesota Rules, part 9520.0910, subparts 1 and 2; and
- (12) Minnesota Rules, part 9520.0914, subpart 2.

Subd. 4c. **Requirements for initial evaluations.** (a) A CCBHC must complete either an initial evaluation or a comprehensive evaluation as required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(b) Notwithstanding any law to the contrary, an initial evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 245.4711, subdivision 4;
- (2) section 245.4881, subdivisions 3 and 4;
- (3) section 245I.10, subdivision 5;
- (4) section 256B.0623, subdivisions 3, clause (4), 8, and 10;
- (5) section 256B.0943, subdivisions 3 and 6, paragraph (b), clauses (1) and (2);
- (6) Minnesota Rules, part 9520.0909, subpart 1;

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- (7) Minnesota Rules, part 9520.0910, subpart 1;
- (8) Minnesota Rules, part 9520.0914, subpart 2;
- (9) Minnesota Rules, part 9520.0918, subparts 1 and 2; and
- (10) Minnesota Rules, part 9520.0919, subpart 2.

Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment plan must be completed within 60 calendar days following the preliminary screening and risk assessment and updated no less frequently than every six months or when the client's circumstances change.

(b) Only a mental health professional may complete an integrated treatment plan. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate. An alcohol and drug counselor may approve the integrated treatment plan. The integrated treatment plan must be developed through a shared decision-making process with the client, the client's support system if the client chooses, or, for children, with the family or caregivers.

(c) The integrated treatment plan must:

- (1) use the ASAM 6 dimensional framework; and
- (2) incorporate prevention, medical and behavioral health needs, and service delivery.

(d) The psychiatric evaluation and management service fulfills requirements for the integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC must complete an integrated treatment plan within 60 calendar days of a client's referral for additional CCBHC services.

(e) Notwithstanding any law to the contrary, an integrated treatment plan developed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 245G.06, subdivision 1;
- (2) section 245G.09, subdivision 3, paragraph (a), clause (6);
- (3) section 245I.10, subdivisions 7 and 8; and
- (4) section 256B.0943, subdivision 6, paragraph (b), clause (2).

Subd. 4e. **Additional licensing and certification requirements.** (a) This subdivision applies to programs and clinics that are a part of a CCBHC.

(b) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the licensing requirements for substance use disorder treatment programs under chapter 245G.

(c) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the certification requirements for mental health clinics under section 245I.20.

(d) The Department of Human Services licensing division will review, inspect, and investigate for compliance with the requirements in subdivisions 4b to 4d for programs or clinics subject to this subdivision.

Subd. 7. **Addition of CCBHCs to section 223 state demonstration programs.** (a) If the commissioner's request under subdivision 6 to reenter the demonstration program established by section 223 of the Protecting Access to Medicare Act is approved, upon reentry the commissioner must follow all federal guidance on the addition of CCBHCs to section 223 state demonstration programs.

(b) Prior to participating in the demonstration, a CCBHC must meet the demonstration certification criteria and prospective payment system guidance in effect at that time and be certified as a CCBHC by the state. The Substance Abuse and Mental Health Services Administration attestation process for CCBHC expansion grants is not sufficient to constitute state certification. CCBHCs newly added to the demonstration must participate in all aspects of the state demonstration program, including but not limited to quality measurement and reporting, evaluation activities, and state CCBHC demonstration program requirements, such as use of state-specified evidence-based practices. A newly added CCBHC must report on quality measures before its first full demonstration year if it joined the demonstration program in calendar year 2023 out of alignment with the state's

demonstration year cycle. A CCBHC may provide services in multiple locations and in community-based settings subject to federal rules of the 223 demonstration authority or Medicaid state plan authority.

(c) If a CCBHC meets the definition of a satellite facility, as defined by the Substance Abuse and Mental Health Services Administration, and was established after April 1, 2014, the CCBHC cannot receive payment as a part of the demonstration program.

Subd. 8. **Grievance procedures required.** CCBHCs and designated collaborating organizations must allow all service recipients access to grievance procedures, which must satisfy the minimum requirements of medical assistance and other grievance requirements such as those that may be mandated by relevant accrediting entities.

245A.10 FEES.

Subd. 3a. **Fee for change of ownership exception.** (a) A license holder must submit a fee of \$2,100 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(b) License holders under chapter 245D must submit a fee of \$4,200 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(c) A license holder for a children's residential facility must submit a fee of \$500 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies of all direct service providers and volunteers for children's therapeutic services and supports providers under section 256B.0943.

245I.20 MENTAL HEALTH CLINIC.

Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification holder must develop a written quality assurance and improvement plan that includes a plan for:

- (1) encouraging ongoing consultation among members of the treatment team;
- (2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;
- (3) measuring and evaluating client outcomes;
- (4) reviewing client suicide deaths and suicide attempts;
- (5) examining the quality of clinical service delivery to clients; and
- (6) self-monitoring of compliance with this chapter.

(b) At least annually, the certification holder must review, evaluate, and update the quality assurance and improvement plan. The review must: (1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and (2) establish goals for improved service delivery to clients for the next year.

245I.23 INTENSIVE RESIDENTIAL TREATMENT SERVICES AND RESIDENTIAL CRISIS STABILIZATION.

Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop a written quality assurance and improvement plan that includes a plan to:

- (1) encourage ongoing consultation between members of the treatment team;
- (2) obtain and evaluate feedback about services from clients, family and other natural supports, referral sources, and staff persons;
- (3) measure and evaluate client outcomes in the program;
- (4) review critical incidents in the program;
- (5) examine the quality of clinical services in the program; and
- (6) self-monitor the license holder's compliance with this chapter.

(b) At least annually, the license holder must review, evaluate, and update the license holder's quality assurance and improvement plan. The license holder's review must:

(1) document the actions that the license holder will take in response to the information that the license holder obtains from the monitoring activities in the plan; and

(2) establish goals for improving the license holder's services to clients during the next year.

256B.055 ELIGIBILITY CATEGORIES.

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the eligibility requirements in section 256B.056, is not eligible for medical assistance, except for covered services received while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues, including costs, related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

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

(a) "Adult rehabilitative mental health services" means the services described in section 245I.02, subdivision 33.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) State-level recertification must occur at least every three years.

(d) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(e) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train qualified staff;

(2) have adequate administrative ability to ensure availability of services;

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(3) ensure that staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

(7) keep all necessary records required by law;

(8) deliver services as required by section 245.461;

(9) be an enrolled Medicaid provider; and

(10) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services.

Subd. 5. Qualifications of provider staff. Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified as:

(1) a mental health professional who is qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist who is qualified according to section 245I.04, subdivision 8;

(3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

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

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

(7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

Subd. 6. Required supervision. (a) A treatment supervisor providing treatment supervision required by section 245I.06 must:

(1) meet with staff receiving treatment supervision at least monthly to discuss treatment topics of interest and treatment plans of recipients; and

(2) meet at least monthly with the directing clinical trainee or mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing clinical trainee or mental health practitioner.

(b) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The treatment director must:

(1) ensure the direct observation of mental health rehabilitation workers required by section 245I.06, subdivision 3, is provided;

(2) ensure immediate availability by phone or in person for consultation by a mental health professional, certified rehabilitation specialist, clinical trainee, or a mental health practitioner to the mental health rehabilitation worker during service provision;

(3) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(4) ensure that clinical trainees, mental health practitioners, and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(5) oversee the record of the results of direct observation, progress note evaluation, and corrective actions taken to modify the work of the clinical trainees, mental health practitioners, and mental health rehabilitation workers.

(c) A clinical trainee or mental health practitioner who is providing treatment direction for a provider entity must receive treatment supervision at least monthly to:

- (1) identify and plan for general needs of the recipient population served;
- (2) identify and plan to address provider entity program needs and effectiveness;
- (3) identify and plan provider entity staff training and personnel needs and issues; and
- (4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health services must complete a written functional assessment according to section 245I.10, subdivision 9, for each recipient.

(b) When a provider of adult rehabilitative mental health services completes a written functional assessment, the provider must also complete a level of care assessment as defined in section 245I.02, subdivision 19, for the recipient.

256B.0624 CRISIS RESPONSE SERVICES COVERED.

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

(a) "Certified rehabilitation specialist" means a staff person who is qualified under section 245I.04, subdivision 8.

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or a qualified member of a crisis team, as described in subdivision 6a.

(d) "Crisis intervention" means face-to-face, short-term intensive mental health services initiated during a mental health crisis to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning.

(e) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

(f) "Crisis stabilization" means individualized mental health services provided to a recipient that are designed to restore the recipient to the recipient's prior functional level. Crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, a short-term supervised, licensed residential program, or an emergency department. Crisis stabilization services includes family psychoeducation.

(g) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

(h) "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

(i) "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

(j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient's levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.

(k) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

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(l) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

(m) "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

(n) "Mobile crisis services" means screening, assessment, intervention, and community-based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

Subd. 3. **Eligibility.** (a) A recipient is eligible for crisis assessment services when the recipient has screened positive for a potential mental health crisis during a crisis screening.

(b) A recipient is eligible for crisis intervention services and crisis stabilization services when the recipient has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4a. **Alternative provider standards.** If a county or Tribe demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph (b), the commissioner may approve an alternative plan proposed by a county or Tribe. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of mobile crisis services;

(2) provide mobile crisis services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

(e) Team members must be experienced in crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources.

Subd. 6. **Crisis screening.** (a) The crisis screening may use the resources of emergency services as defined in section 245.469, subdivisions 1 and 2. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting the crisis screening of a recipient, a provider must:

(1) employ evidence-based practices to reduce the recipient's risk of suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the recipient's mental health crisis, including responding to the recipient's immediate need for support by telephone or text message until the provider can respond to the recipient face-to-face;

(3) document significant factors in determining whether the recipient is experiencing a mental health crisis, including prior requests for crisis services, a recipient's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of a recipient's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including means reduction, to relevant third parties including family members or other persons living with the recipient; and

(6) consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis and the provider must prioritize providing a face-to-face crisis assessment of the recipient, unless a provider documents specific evidence to show why this was not possible, including insufficient staffing resources, concerns for staff or recipient safety, or other clinical factors:

(1) the recipient presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the recipient to determine that the recipient is experiencing a potential mental health crisis. A mobile crisis provider may gather relevant information about the recipient from a third party to establish the recipient's need for services and potential safety factors.

Subd. 6a. **Crisis assessment.** (a) If a recipient screens positive for a potential mental health crisis, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which services are needed and, as time permits, the recipient's current life situation, health information, including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described under subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the recipient's location whenever possible.

(c) Whenever possible, the assessor must attempt to include input from the recipient and the recipient's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes: (1) determining (i) whether the recipient is willing to voluntarily engage in treatment, or (ii) whether the recipient has an advance directive, and (2) gathering the recipient's information and history from involved family or other natural supports.

(e) A crisis assessment must include coordinated response with other health care providers if the assessment indicates that a recipient needs detoxification, withdrawal management, or medical

stabilization in addition to crisis response services. If the recipient does not need an acute level of care, a team must serve an otherwise eligible recipient who has a co-occurring substance use disorder.

(f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the recipient's crisis assessment must immediately contact the referral entity and consult with the triage nurse or other staff responsible for intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the recipient's referral. Following the immediate consultation, the provider must also send written documentation upon completion. The provider must document if these releases occurred with authorization by the recipient, the recipient's legal guardian, or as allowed by section 144.293, subdivision 5.

Subd. 6b. Crisis intervention services. (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be providing face-to-face crisis intervention services. If providing crisis intervention services, a clinical trainee or mental health practitioner must seek treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(c) The mobile crisis intervention team must develop a crisis treatment plan according to subdivision 11.

(d) The mobile crisis intervention team must document which crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

(e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

(f) If the recipient's mental health crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. Crisis stabilization services. (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis treatment plan must be developed that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8;

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis treatment plan, skills training, and collaboration with other service providers in the community; and

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The commissioner shall establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider for the same service to other payers. Payment shall not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The commissioner shall recalculate the statewide per diem every year.

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Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. A staff member providing crisis stabilization services to a recipient must be qualified as a:

- (1) mental health professional;
- (2) certified rehabilitation specialist;
- (3) clinical trainee;
- (4) mental health practitioner;
- (5) mental health certified family peer specialist;
- (6) mental health certified peer specialist; or
- (7) mental health rehabilitation worker.

(b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

(c) For providers who deliver care to children 21 years of age and younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children and include the following topics:

- (1) developmental tasks of childhood and adolescence;
- (2) family relationships;
- (3) child and youth engagement and motivation, including motivational interviewing;
- (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;
- (5) positive behavior support;
- (6) crisis intervention for youth with developmental disabilities;
- (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and
- (8) youth substance use.

This paragraph does not apply to adult residential crisis stabilization service providers licensed according to section 245I.23.

Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and crisis intervention services if the following treatment supervision requirements are met:

- (1) the mental health provider entity must accept full responsibility for the services provided;
- (2) the mental health professional of the provider entity must be immediately available by phone or in person for treatment supervision;
- (3) the mental health professional is consulted, in person or by phone, during the first three hours when a clinical trainee or mental health practitioner provides crisis assessment or crisis intervention services; and
- (4) the mental health professional must:
 - (i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the recipient, notwithstanding section 245I.08, subdivision 3; and
 - (ii) document the consultation required in clause (3).

Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of the recipient's admission, the provider entity must complete the recipient's crisis treatment plan. The provider entity must:

- (1) base the recipient's crisis treatment plan on the recipient's crisis assessment;
- (2) consider crisis assistance strategies that have been effective for the recipient in the past;

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(3) for a child recipient, use a child-centered, family-driven, and culturally appropriate planning process that allows the recipient's parents and guardians to observe or participate in the recipient's individual and family treatment services, assessment, and treatment planning;

(4) for an adult recipient, use a person-centered, culturally appropriate planning process that allows the recipient's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the recipient's treatment planning. The recipient, if possible, must be a participant;

(6) identify the recipient's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the recipient engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the recipient or the recipient's legal guardian approves under section 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the recipient disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of the recipient's treatment plan within 24 hours of the recipient's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the recipient and the recipient's legal guardian with a copy of the recipient's crisis treatment plan.

256B.0701 RECUPERATIVE CARE SERVICES.

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners of the provider who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

- (1) state and federal program billing, documentation, and service delivery requirements;
- (2) enrollment requirements;
- (3) provider program integrity, including fraud prevention, detection, and penalties;
- (4) fair labor standards;
- (5) workplace safety requirements; and
- (6) recent changes in service requirements.

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

(c) Any recuperative care provider enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

256B.073 ELECTRONIC VISIT VERIFICATION.

Subd. 4. **Provider requirements.** (a) A provider of services may select any electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by a date established by the commissioner to be set after the state-selected electronic visit verification systems for personal care services and home health services are in production. For purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(1)(5). Reimbursement rates for providers must not be reduced as a result of federal action to reduce the federal medical assistance percentage under the 21st Century Cures Act, Public Law 114-255.

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subd. 21. **MnCHOICES assessments; exceptions following institutional stay.** (a) A person receiving home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S may return to a community with home and community-based waiver services under the same waiver without being assessed or reassessed under this section if the person temporarily entered one of the following for 121 or fewer days:

- (1) a hospital;
- (2) an institution of mental disease;
- (3) a nursing facility;
- (4) an intensive residential treatment services program;
- (5) a transitional care unit; or
- (6) an inpatient substance use disorder treatment setting.

(b) Nothing in paragraph (a) changes annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

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.

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

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

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

(d) The assessment conducted under this section must:

- (1) verify current assessed support needs;
- (2) confirm continued need for the currently assessed level of care;
- (3) inform the person of alternative long-term services and supports available;
- (4) provide informed choice of institutional or home and community-based services; and
- (5) identify changes in need that may require a full reassessment.

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

(f) The person has appeal rights under section 256.045, subdivision 3, if the assessor does not confirm that there are no changes in needs or services.

256B.0921 HOME AND COMMUNITY-BASED SERVICES INNOVATION POOL.

The commissioner of human services shall develop an initiative to provide incentives for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated competitive employment for youth under age 25 upon their graduation from school; (3) living in the most integrated setting; and (4) other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes.

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

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

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness, as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

(g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered services through telehealth as defined under section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

(i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

(j) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

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(l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

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

(n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

(o) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given in section 245.4871, subdivision 15, for children under 18 years of age.

(p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

(q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

(r) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(t) "Treatment supervision" means the supervision described in section 245I.06.

Subd. 4. Provider entity certification. (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis planning. The commissioner shall recertify a provider entity every three years using the individual provider's certification anniversary or the calendar year end, whichever is later. The commissioner may approve a recertification extension, in the interest of sustaining services, when a certain date for recertification is identified. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) The commissioner must provide the following to providers for the certification, recertification, and decertification processes:

(1) a structured listing of required provider certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification, signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner, if applicable.

(c) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required under section 245I.011, subdivision 5, and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

- (2) a county-operated entity certified by the state; or
- (3) a noncounty entity certified by the state.

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence.

(b) In addition to the policies and procedures required under section 245I.03, the policies and procedures must include:

(1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

(2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals.

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Subd. 5a. **Background studies.** The requirements for background studies under section 245I.011, subdivision 5, paragraph (b), may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment. When required components of the standard diagnostic assessment are not provided in an outside or independent assessment or cannot be attained immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the information into the child's individual treatment plan;

(2) developing an individual treatment plan;

(3) providing treatment supervision plans for staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation;

(4) requiring a mental health professional to determine the level of supervision for a behavioral health aide and to document and sign the supervision determination in the behavioral health aide's supervision plan;

(5) ensuring the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family.

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as a:

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- (1) mental health professional;
- (2) clinical trainee;
- (3) mental health practitioner;
- (4) mental health certified family peer specialist; or
- (5) mental health behavioral aide.

(c) A day treatment team must include one mental health professional or clinical trainee.

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a team under the treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

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(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

(iv) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(v) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

Subd. 11. Documentation and billing. (a) A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

(b) Required documentation must be completed for each individual provider and service modality for each day a child receives a service under subdivision 2, paragraph (b).

9505.2165 DEFINITIONS.

Subp. 4. **Fraud.** "Fraud" means:

A. acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

- (1) theft in violation of Minnesota Statutes, section 609.52;
- (2) perjury in violation of Minnesota Statutes, section 609.48;
- (3) aggravated forgery and forgery in violation of Minnesota Statutes, sections 609.625 and 609.63;
- (4) medical assistance fraud in violation of Minnesota Statutes, section 609.466; and
- (5) financial transaction card fraud in violation of Minnesota Statutes, section 609.821;

B. making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and

C. a felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.