State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 2900

03/15/2023 Authored by Liebling and Long
The bill was read for the first time and referred to the Committee on Rules and Legislative Administration
03/16/2023 Adoption of Report: Re-referred to the Committee on Health Finance and Policy

A bill for an act

relating to state government; modifying provisions governing child care, child safety and permanency, child support, economic assistance, deep poverty, housing and homelessness, behavioral health, the medical education and research cost account, MinnesotaCare, the Tribal Elder Office, background studies, and licensing; making forecast adjustments; requiring reports; transferring money; making technical and conforming changes; allocating funds for a specific purpose; establishing certain grants; appropriating money; amending Minnesota Statutes 2022, sections 62A.045; 62A.673, subdivision 2; 62J.692, subdivisions 1, 3, 4, 5, 8; 119B.011, subdivisions 2, 5, 13, 19a; 119B.025, subdivision 4; 119B.03, subdivision 4a; 119B.125, subdivisions 1, 1a, 1b, 2, 3, 4, 6, 7; 119B.13, subdivisions 1, 6; 119B.16, subdivisions 1c, 3; 119B.161, subdivisions 2, 3; 119B.19, subdivision 7; 145.4716, subdivision 3; 245.095; 245.4889, subdivision 1; 245A.02, subdivision 2c; 245A.04, subdivisions 1, 7, 7a; 245A.05; 245A.055, subdivision 2; 245A.06, subdivisions 1, 2, 4; 245A.07, subdivision 3, by adding subdivisions; 245A.10, subdivision 6, by adding a subdivision; 245A.16, by adding a subdivision; 245A.50, subdivisions 3, 4, 5, 6, 9; 245C.04, subdivision 1; 245C.05, subdivision 4; 245C.10, subdivisions 1d, 2, 3, 4, 5, 6, 8, 9, 9a, 10, 11, 12, 13, 14, 16, 17, 20, 21, by adding a subdivision; 245C.17, subdivision 6; 245C.23, subdivision 2; 245C.32, subdivision 2; 245H.01, subdivision 3, by adding a subdivision; 245H.03, subdivisions 2, 3, 4; 245H.06, subdivisions 1, 2; 245H.07, subdivisions 1, 2; 245I.20, subdivisions 10, 13, 14, 16; 254B.02, subdivision 5; 254B.05, subdivision 1; 256.046, subdivision 3; 256.0471, subdivision 1; 256.969, subdivisions 2b, 9, 25; 256.983, subdivision 5; 256B.055, subdivision 17; 256B.056, subdivision 7; 256B.0625, subdivisions 5m, 9, 13c, 13e, 28b, 30, by adding a subdivision; 256B.0631, subdivision 1; 256B.0638, subdivisions 1, 2, 4, 5, by adding a subdivision; 256B.064, subdivision 1a; 256B.0924, subdivision 5; 256B.0941, by adding a subdivision; 256B.196, subdivision 2; 256B.69, subdivision 5a; 256B.75; 256B.76, subdivisions 1, 2, 4; 256D.01, subdivision 1a; 256D.024, subdivision 1; 256D.03, by adding a subdivision; 256D.06, subdivision 5; 256D.63, subdivision 2; 256E.34, subdivision 4; 256E.35, subdivisions 1, 2, 3, 4a, 6, 7; 256I.03, subdivisions 7, 13; 256I.04, subdivision 1; 256I.06, subdivisions 6, 8, by adding a subdivision; 256J.08, subdivisions 71, 79; 256J.21, subdivisions 3, 4; 256J.26, subdivision 1; 256J.33, subdivisions 1, 2; 256J.37, subdivisions 3, 3a; 256J.95, subdivision 19; 256K.45, subdivisions 3, 7; 256L.04, subdivisions 1c, 7a, 10, by adding a subdivision; 256L.07, subdivision 1; 256L.15, subdivision 2; 256P.01, by adding subdivisions; 256P.02, subdivision 2, by adding a subdivision; 256P.04, subdivisions 4, 8; 256P.06, subdivision 3, by adding a subdivision; 256P.07,

subdivisions 1, 2, 3, 4, 6, 7, by adding subdivisions; 260.761, subdivision 2; 260C.007, subdivision 14; 260C.451, by adding subdivisions; 260C.452, by adding a subdivision; 260C.605, subdivision 1, by adding a subdivision; 260C.704; 260E.01; 260E.02, subdivision 1; 260E.03, subdivision 22, by adding subdivisions; 260E.09; 260E.14, subdivisions 2, 5; 260E.17, subdivision 1; 260E.18; 260E.20, subdivision 2; 260E.24, subdivisions 2, 7; 260E.33, subdivision 1; 260E.35, subdivision 6; 270B.14, subdivision 1; 297F.10, subdivision 1; 518A.31; 518A.32, subdivisions 3, 4; 518A.34; 518A.41; 518A.42, subdivisions 1, 3; 518A.65; 518A.77; 609B.425, subdivision 2; 609B.435, subdivision 2; Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended; Laws 2021, First Special Session chapter 7, article 1, section 36; article 6, section 26; article 16, section 2, subdivision 32, as amended; article 17, section 5, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 119B; 245; 256; 256D; 256E; 256K; 256P; 260; proposing coding for new law as Minnesota Statutes, chapter 245J; repealing Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, 7a; 119B.03, subdivision 4; 137.38, subdivision 1; 245.735, subdivision 3; 245C.02, subdivision 14b; 245C.032; 245C.11, subdivision 3; 245C.30, subdivision 1a; 256.8799; 256.9864; 256B.69, subdivision 5c; 256J.08, subdivisions 10, 53, 61, 62, 81, 83; 256J.30, subdivisions 5, 7, 8; 256J.33, subdivisions 3, 4, 5; 256J.34, subdivisions 1, 2, 3, 4; 256J.37, subdivision 10.

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

ARTICLE 1

CHILD CARE

Section 1. Minnesota Statutes 2022, section 119B.011, subdivision 2, is amended to read:

Subd. 2. **Applicant.** "Child care fund applicants" means all parents~~,~~; stepparents~~,~~; legal guardians~~, or~~; eligible relative caregivers ~~who are~~; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodians or guardians as established by section 256N.22, subdivision 10; or foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b. Applicants must be members of the family and reside in the household that applies for child care assistance under the child care fund.

EFFECTIVE DATE. This section is effective August 25, 2024.

Sec. 2. Minnesota Statutes 2022, section 119B.011, subdivision 5, is amended to read:

Subd. 5. **Child care.** "Child care" means the care of a child by someone other than a parent~~,~~; stepparent~~,~~; legal guardian~~,~~; eligible relative caregiver~~,~~; relative custodian who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodian or guardian as established according to section 256N.22, subdivision 10; foster parent providing care to a child placed in a family foster home under section 260C.007,

subdivision 16b; or ~~the spouses~~ spouse of any of the foregoing in or outside the child's own home for gain or otherwise, on a regular basis, for any part of a 24-hour day.

EFFECTIVE DATE. This section is effective August 25, 2024.

Sec. 3. Minnesota Statutes 2022, section 119B.011, subdivision 13, is amended to read:

Subd. 13. **Family.** "Family" means parents~~,~~; stepparents~~,~~; guardians and their spouses~~,~~ ~~or~~; other eligible relative caregivers and their spouses~~,~~; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code, and their spouses; successor custodians or guardians as established by section 256N.22, subdivision 10, and their spouses; foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b, and their spouses; and ~~their blood related~~ the blood-related dependent children and adoptive siblings under the age of 18 years living in the same home ~~including~~ as any of the above. Family includes children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities ~~or parents, stepparents, guardians and their spouses, or other relative caregivers and their spouses~~ and adults temporarily absent from the household in settings such as schools, military service, or rehabilitation programs. An adult family member who is not in an authorized activity under this chapter may be temporarily absent for up to 60 days. When a minor parent or parents and his, her, or their child or children are living with other relatives, and the minor parent or parents apply for a child care subsidy, "family" means only the minor parent or parents and their child or children. An adult age 18 or older who meets this definition of family and is a full-time high school or postsecondary student may be considered a dependent member of the family unit if 50 percent or more of the adult's support is provided by the parents~~,~~; stepparents~~,~~; guardians and their spouses; relative custodians who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code, and their spouses; successor custodians or guardians as established by section 256N.22, subdivision 10, and their spouses; foster parents providing care to a child placed in a family foster home under section 260C.007, subdivision 16b, and their spouses; or eligible relative caregivers and their spouses residing in the same household.

EFFECTIVE DATE. This section is effective August 25, 2024.

Sec. 4. Minnesota Statutes 2022, section 119B.011, subdivision 19a, is amended to read:

Subd. 19a. **Registration.** "Registration" means the process used by ~~a county~~ the commissioner to determine whether the provider selected by a family applying for or receiving child care assistance to care for that family's children meets the requirements necessary for payment of child care assistance for care provided by that provider. The commissioner shall create a process for statewide registration by April 28, 2025.

Sec. 5. Minnesota Statutes 2022, section 119B.03, subdivision 4a, is amended to read:

Subd. 4a. ~~**Temporary reprioritization**~~ **Funding priorities.** (a) ~~Notwithstanding subdivision 4~~ In the event that inadequate funding necessitates the use of waiting lists, priority for child care assistance under the basic sliding fee assistance program shall be determined according to this subdivision ~~beginning July 1, 2021, through May 31, 2024~~.

(b) First priority must be given to eligible non-MFIP families who do not have a high school diploma or commissioner of education-selected high school equivalency certification or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(c) Second priority must be given to families in which at least one parent is a veteran, as defined under section 197.447.

(d) Third priority must be given to eligible families who do not meet the specifications of paragraph (b), (c), (e), or (f).

(e) Fourth priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(f) Fifth priority must be given to eligible families receiving services under section 119B.011, subdivision 20a, if the parents have completed their MFIP or DWP transition year, or if the parents are no longer receiving or eligible for DWP supports.

(g) Families under paragraph (f) must be added to the basic sliding fee waiting list on the date they complete their transition year under section 119B.011, subdivision 20.

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

Sec. 6. Minnesota Statutes 2022, section 119B.125, subdivision 1, is amended to read:

Subdivision 1. **Authorization.** ~~A county or~~ The commissioner must authorize the provider chosen by an applicant or a participant before the county can authorize payment for care provided by that provider. The commissioner must establish the requirements necessary for authorization of providers. A provider must be reauthorized every two years. ~~A legal, nonlicensed family child care provider also must be reauthorized when another person over the age of 13 joins the household, a current household member turns 13, or there is reason to believe that a household member has a factor that prevents authorization. The provider is required to report all family changes that would require reauthorization. When a provider has been authorized for payment for providing care for families in more than one county, the county responsible for reauthorization of that provider is the county of the family with a current authorization for that provider and who has used the provider for the longest length of time.~~

Sec. 7. Minnesota Statutes 2022, section 119B.125, subdivision 1a, is amended to read:

Subd. 1a. **Background study required.** (a) This subdivision only applies to legal, nonlicensed family child care providers.

(b) Prior to authorization, ~~and as part of each reauthorization required in subdivision 1, the county~~ the commissioner shall perform a background study on ~~every member of the provider's household who is age 13 and older. The county shall also perform a background study on an individual who has reached age ten but is not yet age 13 and is living in the household where the nonlicensed child care will be provided when the county has reasonable cause as defined under section 245C.02, subdivision 15~~ individuals identified under section 245C.02, subdivision 6a.

(c) After authorization, a background study shall also be performed when an individual identified under section 245C.02, subdivision 6a, joins the household. The provider must report all family changes that would require a new background study.

(d) At each reauthorization, the commissioner shall ensure that a background study through NETStudy 2.0 has been performed on all individuals in the provider's household for whom a background study is required under paragraphs (b) and (c).

(e) Prior to a background study through NETStudy 2.0 expiring, another background study shall be completed on all individuals for whom the background study is expiring.

Sec. 8. Minnesota Statutes 2022, section 119B.125, subdivision 1b, is amended to read:

Subd. 1b. **Training required.** (a) ~~Effective November 1, 2011,~~ Prior to initial authorization as required in subdivision 1, a legal nonlicensed family child care provider must complete first aid and CPR training and provide the verification of first aid and CPR training to the ~~county~~ commissioner. The training documentation must have valid effective dates as of the date the registration request is submitted to the ~~county~~ commissioner. The training must have been provided by an individual approved to provide first aid and CPR instruction and have included CPR techniques for infants and children.

~~(b) Legal nonlicensed family child care providers with an authorization effective before November 1, 2011, must be notified of the requirements before October 1, 2011, or at authorization, and must meet the requirements upon renewal of an authorization that occurs on or after January 1, 2012.~~

~~(c)~~ (b) Upon each reauthorization after the authorization period when the initial first aid and CPR training requirements are met, a legal nonlicensed family child care provider must provide verification of at least eight hours of additional training listed in the Minnesota Center for Professional Development Registry.

~~(d)~~ (c) This subdivision only applies to legal nonlicensed family child care providers.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 9. Minnesota Statutes 2022, section 119B.125, subdivision 2, is amended to read:

Subd. 2. **Persons who cannot be authorized.** (a) The provider seeking authorization under this section shall collect the information required under section 245C.05~~, subdivision 1,~~ and forward the information to the ~~county agency~~ commissioner. The background study must include a review of the information required under section 245C.08, ~~subdivisions 2,~~ subdivision 3~~, and 4, paragraph (b)~~.

(b) A legal nonlicensed family child care provider is not authorized under this section if:

(1) the commissioner determines that any household member who is the subject of a background study is ~~determined to have a disqualifying characteristic under paragraphs (b) to (e) or under section 245C.14 or 245C.15. If a county has determined that a provider is able to be authorized in that county, and a family in another county later selects that provider, the provider is able to be authorized in the second county without undergoing a new background investigation unless one of the following conditions exists:~~ disqualified from

direct contact with, or from access to, persons served by the program and that disqualification has not been set aside or a variance has not been granted under chapter 245C;

~~(1) two years have passed since the first authorization;~~

~~(2) another person age 13 or older has joined the provider's household since the last authorization;~~

~~(3) a current household member has turned 13 since the last authorization; or~~

~~(4) there is reason to believe that a household member has a factor that prevents authorization.~~

~~(b)~~ (2) the person has refused to give written consent for disclosure of criminal history records~~.~~;

~~(c)~~ (3) the person has been denied a family child care license ~~or has received a fine or a sanction as a licensed child care provider that has not been reversed on appeal.~~;

~~(d)~~ (4) the person has a family child care licensing disqualification that has not been set aside~~.~~; or

~~(e)~~ (5) the person has admitted or a county has found that there is a preponderance of evidence that fraudulent information was given to the county for child care assistance application purposes or was used in submitting child care assistance bills for payment.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 10. Minnesota Statutes 2022, section 119B.125, subdivision 3, is amended to read:

Subd. 3. **Authorization exception.** When ~~a county~~ the commissioner denies a person authorization as a legal nonlicensed family child care provider under subdivision 2, the ~~county~~ commissioner later may authorize that person as a provider if the following conditions are met:

(1) after receiving notice of the denial of the authorization, the person applies for and obtains a valid child care license issued under chapter 245A, issued by a tribe, or issued by another state;

(2) the person maintains the valid child care license; and

(3) the person is providing child care in the state of licensure or in the area under the jurisdiction of the licensing tribe.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 11. Minnesota Statutes 2022, section 119B.125, subdivision 4, is amended to read:

Subd. 4. **Unsafe care.** ~~A county~~ The commissioner may deny authorization as a child care provider to any applicant or rescind authorization of any provider when ~~the~~ a county or commissioner knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. The ~~county must include the conditions under which a provider or care arrangement will be determined to be unsafe in the county's child care fund plan under section 119B.08, subdivision 3~~ commissioner shall introduce statewide criteria for unsafe care by April 28, 2025.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 12. Minnesota Statutes 2022, section 119B.125, subdivision 6, is amended to read:

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must:

(1) keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance; and

(2) make those records available immediately to the county or the commissioner upon request. Any records not provided to a county or the commissioner at the date and time of the request are deemed inadmissible if offered as evidence by the provider in any proceeding to contest an overpayment or disqualification of the provider.

(b) As a condition of payment, attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

(c) ~~A county or the commissioner may deny or revoke a provider's authorization to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a fraud disqualification under section 256.98, take an action against the provider under chapter 245E, or establish an attendance record overpayment under paragraph (d) against a current or former provider,~~ When the county or the commissioner knows or has reason to believe that ~~the~~ a current or former provider has not complied with the record-keeping requirement in this subdivision~~.~~:

(1) the commissioner may:

(i) deny or revoke a provider's authorization to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d);

(ii) pursue an administrative disqualification under sections 256.046, subdivision 3, and 256.98; or

(iii) take an action against the provider under chapter 245E; or

(2) a county or the commissioner may establish an attendance record overpayment under paragraph (d).

(d) To calculate an attendance record overpayment under this subdivision, the commissioner or county agency shall subtract the maximum daily rate from the total amount paid to a provider for each day that a child's attendance record is missing, unavailable, incomplete, inaccurate, or otherwise inadequate.

(e) The commissioner shall develop criteria for a county to determine an attendance record overpayment under this subdivision.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 13. Minnesota Statutes 2022, section 119B.125, subdivision 7, is amended to read:

Subd. 7. **Failure to comply with attendance record requirements.** (a) In establishing an overpayment claim for failure to provide attendance records in compliance with subdivision 6, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) The commissioner or county may periodically audit child care providers to determine compliance with subdivision 6.

(c) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(d) The commissioner or county shall seek to recoup or recover overpayments paid to a current or former provider.

(e) When a provider has been disqualified or convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recoupment or recovery must be sought regardless of the amount of overpayment.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 14. Minnesota Statutes 2022, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~November 15, 2021~~ October 30, 2023, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be~~:~~

~~(1) for all infants and toddlers,~~ the greater of the ~~40th~~ 75th percentile of the 2021 child care provider rate survey or the rates in effect at the time of the update~~; and~~.

~~(2) for all preschool and school-age children, the greater of the 30th percentile of the 2021 child care provider rate survey or the rates in effect at the time of the update.~~

(b) Beginning the first full service period on or after January 1, 2025, and every three years thereafter, the maximum rate paid for child care assistance in a county or county price cluster under the child care fund shall be~~:~~

~~(1) for all infants and toddlers,~~ the greater of the ~~40th~~ 75th percentile of the ~~2024~~ most recent child care provider rate survey or the rates in effect at the time of the update~~; and~~.

~~(2) for all preschool and school-age children, the greater of the 30th percentile of the 2024 child care provider rate survey or the rates in effect at the time of the update.~~

The rates under paragraph (a) continue until the rates under this paragraph go into effect.

(c) For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(d) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(e) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(f) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(g) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

(h) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(i) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

(j) Beginning October 30, 2023, the maximum registration fee paid for child care assistance in any county or county price cluster under the child care fund shall be ~~set as follows: (1) beginning November 15, 2021,~~ the greater of the ~~40th~~ 75th percentile of the ~~2021~~ most recent child care provider rate survey or the registration fee in effect at the time of the update~~; and (2) beginning the first full service period on or after January 1, 2025, the maximum registration fee shall be the greater of the 40th percentile of the 2024 child care provider rate survey or the registration fee in effect at the time of the update. The registration fees under clause (1) continue until the registration fees under clause (2) go into effect~~.

(k) Maximum registration fees must be set for licensed family child care and for child care centers. For a child care provider located in the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum registration fee paid for child care assistance shall be equal to the maximum registration fee paid in the county with the highest maximum registration fee or the provider's charge, whichever is less.

Sec. 15. Minnesota Statutes 2022, section 119B.13, subdivision 6, is amended to read:

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on

the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of three months from the date the provider is issued an authorization of care and a billing form. For a family at application, if a provider provided child care during a time period without receiving an authorization of care and a billing form, a county may only make child care assistance payments to the provider retroactively from the date that child care began, or from the date that the family's eligibility began under section 119B.09, subdivision 7, or from the date that the family meets authorization requirements, not to exceed six months from the date that the provider is issued an authorization of care and a billing form, whichever is later.

(d) ~~A county or~~ The commissioner may refuse to issue a child care authorization to a certified, licensed, or legal nonlicensed provider, revoke an existing child care authorization to a certified, licensed, or legal nonlicensed provider, stop payment issued to a certified, licensed, or legal nonlicensed provider, or refuse to pay a bill submitted by a certified, licensed, or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) ~~a county or~~ the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license issued by the commissioner; or

(iii) an order of decertification issued to the provider;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request;

(6) the provider gives false child care price information; or

(7) the provider fails to report decreases in a child's attendance as required under section 119B.125, subdivision 9.

(e) For purposes of paragraph (d), clauses (3), (5), (6), and (7), ~~the county or~~ the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(f) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

(g) If the commissioner ~~or responsible county agency~~ suspends or refuses payment to a provider under paragraph (d), clause (1) or (2), or chapter 245E and the provider has:

(1) a disqualification for wrongfully obtaining assistance under section 256.98, subdivision 8, paragraph (c);

(2) an administrative disqualification under section 256.046, subdivision 3; or

(3) a termination under section 245E.02, subdivision 4, paragraph (c), clause (4), or 245E.06;

then the provider forfeits the payment to the commissioner or the responsible county agency, regardless of the amount assessed in an overpayment, charged in a criminal complaint, or ordered as criminal restitution.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 16. Minnesota Statutes 2022, section 119B.16, subdivision 1c, is amended to read:

Subd. 1c. **Notice to providers.** (a) Before taking an action appealable under subdivision 1a, paragraph (b), a county agency or the commissioner must mail written notice to the provider against whom the action is being taken. Unless otherwise specified under this chapter, chapter 245E, or Minnesota Rules, chapter 3400, a county agency or the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date.

(b) The notice shall state (1) the factual basis for the county agency or department's determination, (2) the action the county agency or department intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the department's proposed action.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 17. Minnesota Statutes 2022, section 119B.16, subdivision 3, is amended to read:

Subd. 3. **Fair hearing stayed.** (a) If ~~a county agency or~~ the commissioner denies or revokes a provider's authorization based on a licensing action under section 245A.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues an order as required under section 245A.08, subdivision 5.

(b) If the commissioner denies or revokes a provider's authorization based on decertification under section 245H.07, and the provider appeals, the provider's fair hearing must be stayed until the commissioner issues a final order as required under section 245H.07.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 18. Minnesota Statutes 2022, section 119B.161, subdivision 2, is amended to read:

Subd. 2. **Notice.** (a) ~~A county agency or~~ The commissioner must mail written notice to a provider within five days of suspending payment or denying or revoking the provider's authorization under subdivision 1.

(b) The notice must:

(1) state the provision under which ~~a county agency or~~ the commissioner is denying, revoking, or suspending the provider's authorization or suspending payment to the provider;

(2) set forth the general allegations leading to the denial, revocation, or suspension of the provider's authorization. The notice need not disclose any specific information concerning an ongoing investigation;

(3) state that the denial, revocation, or suspension of the provider's authorization is for a temporary period and explain the circumstances under which the action expires; and

(4) inform the provider of the right to submit written evidence and argument for consideration by the commissioner.

(c) Notwithstanding Minnesota Rules, part 3400.0185, if ~~a county agency or~~ the commissioner suspends payment to a provider under chapter 245E or denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph (d), clause (1) or

(2), a county agency or the commissioner must send notice of service authorization closure to each affected family. The notice sent to an affected family is effective on the date the notice is created.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 19. Minnesota Statutes 2022, section 119B.161, subdivision 3, is amended to read:

Subd. 3. **Duration.** If a provider's payment is suspended under chapter 245E or a provider's authorization is denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (1) or (2), the provider's denial, revocation, temporary suspension, or payment suspension remains in effect until:

(1) the commissioner or a law enforcement authority determines that there is insufficient evidence warranting the action and ~~a county agency or~~ the commissioner does not pursue an additional administrative remedy under chapter 245E or section 256.98; or

(2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 20. Minnesota Statutes 2022, section 119B.19, subdivision 7, is amended to read:

Subd. 7. **Child care resource and referral programs.** Within each region, a child care resource and referral program must:

(1) maintain one database of all existing child care resources and services and one database of family referrals;

(2) provide a child care referral service for families;

(3) develop resources to meet the child care service needs of families;

(4) increase the capacity to provide culturally responsive child care services;

(5) coordinate professional development opportunities for child care and school-age care providers;

(6) administer and award child care services grants;

(7) cooperate with the Minnesota Child Care Resource and Referral Network and its member programs to develop effective child care services and child care resources; ~~and~~

(8) assist in fostering coordination, collaboration, and planning among child care programs and community programs such as school readiness, Head Start, early childhood family

education, local interagency early intervention committees, early childhood screening, special education services, and other early childhood care and education services and programs that provide flexible, family-focused services to families with young children to the extent possible.;

(9) administer the child care one-stop regional assistance network to assist child care providers and individuals interested in becoming child care providers with establishing and sustaining a licensed family child care or group family child care program or a child care center; and

(10) provide supports that enable economically challenged individuals to obtain the jobs skills training, career counseling, and job placement assistance necessary to begin a career path in child care.

Sec. 21. **[119B.27] CHILD CARE RETENTION PROGRAM.**

Subdivision 1. **Establishment.** A child care retention program is established to provide eligible child care programs with payments to improve access to child care in Minnesota and to strengthen the ability of child care programs to recruit and retain qualified early educators to work in child care programs. The child care retention program shall be administered by the commissioner of human services.

Subd. 2. **Eligible programs.** (a) The following programs are eligible to receive child care retention payments under this section:

(1) family and group family child care homes licensed under Minnesota Rules, chapter 9502;

(2) child care centers licensed under Minnesota Rules, chapter 9503;

(3) certified license-exempt child care centers under chapter 245H;

(4) Tribally licensed child care programs; and

(5) other programs as determined by the commissioner.

(b) To be eligible, programs must not be:

(1) the subject of a finding of fraud for which the program or individual is currently serving a penalty or exclusion;

(2) the subject of suspended, denied, or terminated payments to a provider under section 256.98, subdivision 1; 119B.13, subdivision 6, paragraph (d), clauses (1) and (2); or 245E.02, subdivision 4, paragraph (c), clause (4), regardless of whether the action is under appeal;

(3) prohibited from receiving public funds under section 245.095, regardless of whether the action is under appeal; or

(4) under license revocation, suspension, temporary immediate suspension, or decertification, regardless of whether the action is under appeal.

Subd. 3. **Requirements.** (a) As a condition of payment, all providers receiving retention payments under this section must:

(1) complete an application developed by the commissioner for each payment period for which the eligible program applies for funding;

(2) attest and agree in writing that the program intends to remain operating and serving a minimum number of children, as determined by the commissioner, for the duration of the payment period, with the exceptions of:

(i) service disruptions that are necessary to protect the safety and health of children and child care programs based on public health guidance issued by the Centers for Disease Control and Prevention, the commissioner of health, the commissioner of human services, or a local public health agency; and

(ii) planned temporary closures for provider vacation and holidays during each payment period. The maximum allowed duration of vacations and holidays must be established by the commissioner.

(b) Funds received under this section must be expended by a provider no later than six months after the date the payment was received.

(c) Recipients must comply with all requirements listed in the application under this section. Methods for demonstrating that requirements have been met shall be determined by the commissioner.

(d) Recipients must keep accurate and legible records of the following at the site where services are delivered:

(1) use of money;

(2) attendance records. Daily attendance records must be completed every day and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off and picked up from the child care provider must be entered by the person dropping off or picking up the child; and

(3) staff employment, compensation, and benefits records. Employment, compensation, and benefits records must include time sheets or other records of daily hours worked and documentation of compensation and benefits.

(e) The requirement to document compensation and benefits only applies to family child care providers if retention payment funds are used for compensation and benefits.

(f) All records must be retained at the site where services are delivered for six years after the date of receipt of payment and be made immediately available to the commissioner upon request. Any records not provided to the commissioner at the date and time of the request are deemed inadmissible if offered as evidence by a provider in any proceeding to contest an overpayment or disqualification of the provider.

(g) Recipients that fail to meet the requirements under this section are subject to discontinuation of future installment payments, recovery of overpayments, and actions under chapter 245E. Except when based on a finding of fraud, actions to establish an overpayment must be made within six years of receipt of the payments. Once an overpayment is established, collection may continue until funds have been repaid in full. The appeal process under section 119B.16 applies to actions taken for failure to meet the requirements of this section.

Subd. 4. **Providing payments.** (a) The commissioner shall provide retention payments under this section to all eligible programs on a noncompetitive basis.

(b) The commissioner shall award retention payments to all eligible programs. The payment amounts shall be based on the number of full-time equivalent staff who regularly care for children in the program, including any employees, sole proprietors, or independent contractors.

(c) One full-time equivalent is defined as an individual caring for children 32 hours per week. An individual can count as more or less than one full-time equivalent staff, but as no more than two full-time equivalent staff.

(d) The amount awarded per full-time equivalent individual caring for children for each payment type must be established by the commissioner.

(e) Payments must be increased by 25 percent for providers receiving payments through the child care assistance programs under section 119B.03 or 119B.05 or early learning scholarships under section 124D.165 or whose program is located in a child care access equity area. Child care access equity areas are areas with low access to child care, high poverty rates, high unemployment rates, low home ownership rates, and low median

household incomes. The commissioner must develop a method for establishing child care access equity areas.

(f) The commissioner shall make payments to eligible programs under this section in the form, frequency, and manner established by the commissioner.

Subd. 5. **Eligible uses of money.** (a) Recipients that are child care centers licensed under Minnesota Rules, chapter 9503; certified license-exempt child care centers under chapter 245H; or Tribally licensed child care centers must use money provided under this section to pay for increases in compensation, benefits, premium pay, or additional federal taxes assessed on the compensation of employees as a result of paying increased compensation or premium pay to all paid employees or independent contractors regularly caring for children. The increases in this paragraph must occur no less frequently than once per year.

(b) Recipients that are family and group family child care homes licensed under Minnesota Rules, chapter 9502, or are Tribally licensed family child care homes shall use money provided under this section for one or more of the following uses:

(1) paying personnel costs, such as payroll, salaries, or similar compensation; employee benefits; premium pay; or employee recruitment and retention for an employee, including a sole proprietor or an independent contractor;

(2) paying rent, including rent under a lease agreement, or making payments on any mortgage obligation, utilities, facility maintenance or improvements, or insurance;

(3) purchasing or updating equipment, supplies, goods, or services;

(4) providing mental health supports for children; or

(5) purchasing training or other professional development.

Subd. 6. **Legal nonlicensed child care provider payments.** (a) Legal nonlicensed child care providers, as defined in section 119B.011, subdivision 16, may be eligible to apply for a payment of up to $500 for costs incurred before the first month when payments from the child care assistance program are issued.

(b) Payments must be used on one or more of the following eligible activities to meet child care assistance program requirements under sections 119B.03 and 119B.05:

(1) purchasing or updating equipment, supplies, goods, or services; or

(2) purchasing training or other professional development.

(c) The commissioner shall determine the form and manner of the application for a payment under this subdivision.

Subd. 7. **Carryforward authority.** Funds appropriated under this section are available until expended.

Subd. 8. **Report.** By January 1 each year, the commissioner must report to the chairs and ranking minority members of the legislative committees with jurisdiction over child care the number of payments provided to recipients and outcomes of the retention payment program since the last report. This subdivision expires January 31, 2033.

Sec. 22. **[119B.28] SHARED SERVICES GRANTS.**

(a) The commissioner of human services shall establish a grant program to distribute funds for the planning, establishment, expansion, improvement, or operation of shared services alliances to allow family child care providers to achieve economies of scale. The commissioner must develop a process to fund organizations to operate shared services alliances that includes application forms, timelines, and standards for renewal. For purposes of this section, "shared services alliances" means networks of licensed family child care providers that share services to reduce costs and achieve efficiencies.

(b) Programs eligible to be a part of the shared services alliances supported through this grant program include:

(1) family child care or group family child care homes licensed under Minnesota Rules, chapter 9502;

(2) Tribally licensed family child care or group family child care; and

(3) individuals in the process of starting a family child care or group family child care home.

(c) Eligible applicants include public entities and private for-profit and nonprofit organizations.

(d) Grantees shall use the grant funds to deliver one or more of the following services:

(1) pooling the management of payroll and benefits, banking, janitorial services, food services, and other operations;

(2) shared administrative staff for tasks such as record keeping and reporting for programs such as the child care assistance program, Head Start, the child and adult care food program, and early learning scholarships;

(3) coordination of bulk purchasing;

(4) management of a substitute pool;

(5) support for implementing shared curriculum and assessments;

(6) mentoring child care provider participants to improve business practices;

(7) provision of and training in child care management software to simplify processes such as enrollment, billing, and tracking expenditures;

(8) support for a group of providers sharing one or more physical spaces within a larger building; or

(9) other services as determined by the commissioner.

(e) The commissioner must develop a process by which grantees will report to the Department of Human Services on activities funded by the grant.

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

Sec. 23. **[119B.29] CHILD CARE PROVIDER ACCESS TO TECHNOLOGY GRANTS.**

(a) The commissioner of human services shall distribute money provided by this section through grants to one or more organizations to offer grants or other supports to child care providers for technology intended to improve the providers' business practices. The commissioner must develop a process to fund organizations to provide technology supports that includes application forms, timelines, reporting requirements, and standards for renewal.

(b) Programs eligible to be supported through this grant program include:

(1) child care centers licensed under Minnesota Rules, chapter 9503;

(2) family or group family child care homes licensed under Minnesota Rules, chapter 9502; and

(3) Tribally licensed centers, family child care, and group family child care.

(c) Eligible applicants include public entities and private for-profit and nonprofit organizations with the ability to develop technology products for child care business management or offer training, technical assistance, coaching, or other supports for child care providers to use technology products for child care business management.

(d) Grantees shall use the grant funds, either directly or through grants to providers, for one or more of the following purposes:

(1) the purchase of computers or mobile devices for use in business management;

(2) access to the Internet through the provision of necessary hardware such as routers or modems or by covering the costs of monthly fees for Internet access;

(3) covering the costs of subscription to child care management software;

(4) covering the costs of training in the use of technology for business management purposes; and

(5) other services as determined by the commissioner.

Sec. 24. Minnesota Statutes 2022, 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 119B.125, subdivision 1a, for a legal nonlicensed child care provider authorized under chapter 119B:

(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.

~~(c)~~ (d) At reapplication for a family child care license:

(1) for a background study affiliated with a licensed family child care center ~~or legal nonlicensed child care provider~~, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed under section 245C.05, subdivision 5;

(2) the county agency shall verify the information received under clause (1) and forward the information to the commissioner and submit the request in NETStudy 2.0 to complete the background study; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.

~~(d)~~ (e) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

~~(e)~~ (f) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster family setting license holder:

(1) the county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5, when the child foster family setting applicant or license holder resides in the home where child foster care services are provided; and

(2) the background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

~~(f)~~ (g) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an 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 chapter 119B 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 119B;

(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.

~~(g)~~ (h) 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 before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(h)~~ (i) 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.

~~(i)~~ (j) 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.

~~(j)~~ (k) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

~~(k)~~ (l) A repeat background study at the time of license renewal is not required if the family child care substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.

~~(l)~~ (m) Before and after school programs authorized under chapter 119B, are exempt from the background study requirements under section 123B.03, for an employee for whom a background study under this chapter has been completed.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 25. Minnesota Statutes 2022, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study information obtained under this section and section 245C.08 to counties and private agencies for background studies conducted by the commissioner for child foster care, including a summary of nondisqualifying results, except as prohibited by law; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care ~~and legal nonlicensed child care authorized under chapter 119B~~.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 26. Minnesota Statutes 2022, section 245C.17, subdivision 6, is amended to read:

Subd. 6. **Notice to county agency.** For studies on individuals related to a license to provide adult foster care when the applicant or license holder resides in the adult foster care

residence and family adult day services and, effective upon implementation of NETStudy 2.0, family child care ~~and legal nonlicensed child care authorized under chapter 119B~~, the commissioner shall also provide a notice of the background study results to the county agency that initiated the background study.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 27. Minnesota Statutes 2022, section 245C.23, subdivision 2, is amended to read:

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the license holder of the disqualification and order the license holder to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder if:

(1) the individual studied does not submit a timely request for reconsideration under section 245C.21;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that license holder under section 245C.22, unless the individual has a right to request a hearing under section 245C.27, 245C.28, or 256.045;

(3) an individual who has a right to request a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(c) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was not previously ordered under section 245C.17 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous direct supervision when providing direct contact services, the commissioner shall order the individual to remain under continuous

direct supervision pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

(d) For background studies related to child foster care when the applicant or license holder resides in the home where services are provided, the commissioner shall also notify the county or private agency that initiated the study of the results of the reconsideration.

(e) For background studies related to family child care, ~~legal nonlicensed child care,~~ adult foster care programs when the applicant or license holder resides in the home where services are provided, and family adult day services, the commissioner shall also notify the county that initiated the study of the results of the reconsideration.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 28. Minnesota Statutes 2022, section 256.046, subdivision 3, is amended to read:

Subd. 3. **Administrative disqualification of child care providers caring for children receiving child care assistance.** (a) The department ~~or local agency~~ shall pursue an administrative disqualification, if the child care provider is accused of committing an intentional program violation, in lieu of a criminal action when it has not been pursued. Intentional program violations include intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E. Intent may be proven by demonstrating a pattern of conduct that violates program rules under chapters 119B and 245E.

(b) To initiate an administrative disqualification, ~~a local agency or~~ the commissioner must mail written notice by certified mail to the provider against whom the action is being taken. Unless otherwise specified under chapter 119B or 245E or Minnesota Rules, chapter 3400, ~~a local agency or~~ the commissioner must mail the written notice at least 15 calendar days before the adverse action's effective date. The notice shall state (1) the factual basis for the agency's determination, (2) the action the agency intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the agency's proposed action.

(c) The provider may appeal an administrative disqualification by submitting a written request to the Department of Human Services, Appeals Division. A provider's request must be received by the Appeals Division no later than 30 days after the date ~~a local agency or~~ the commissioner mails the notice.

(d) The provider's appeal request must contain the following:

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

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

(e) On appeal, the issuing agency bears the burden of proof to demonstrate by a preponderance of the evidence that the provider committed an intentional program violation.

(f) The hearing is subject to the requirements of sections 256.045 and 256.0451. The human services judge may combine a fair hearing and administrative disqualification hearing into a single hearing if the factual issues arise out of the same or related circumstances and the provider receives prior notice that the hearings will be combined.

(g) A provider found to have committed an intentional program violation and is administratively disqualified shall be disqualified, for a period of three years for the first offense and permanently for any subsequent offense, from receiving any payments from any child care program under chapter 119B.

(h) Unless a timely and proper appeal made under this section is received by the department, the administrative determination of the department is final and binding.

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 29. Minnesota Statutes 2022, section 256.983, subdivision 5, is amended to read:

Subd. 5. **Child care providers; financial misconduct.** (a) A county or tribal agency may conduct investigations of financial misconduct by child care providers as described in chapter 245E. Prior to opening an investigation, a county or tribal agency must contact the commissioner to determine whether an investigation under this chapter may compromise an ongoing investigation.

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or tribe materially false information on the provider's billing forms, provided false attendance records to a county, tribe, or the commissioner, or committed financial misconduct as described in section 245E.01, subdivision 8, the county or tribal agency may recommend that the commissioner suspend a provider's payment pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section 119B.13, subdivision 6, paragraph (d), clause (2), prior to

pursuing other available remedies. ~~The county or tribe must send notice in accordance with the requirements of section 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law enforcement authority determines that there is insufficient evidence warranting the action and a county, tribe, or the commissioner does not pursue an additional administrative remedy under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.~~

~~(c) For the purposes of this section, an intentional program violation includes intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E.~~

~~(d) A provider has the right to administrative review under section 119B.161 if: (1) payment is suspended under chapter 245E; or (2) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (2).~~

EFFECTIVE DATE. This section is effective April 28, 2025.

Sec. 30. **DIRECTION TO COMMISSIONER; TRANSITION CHILD CARE STABILIZATION GRANTS.**

(a) The commissioner of human services must continue providing child care stabilization grants under Laws 2021, First Special Session chapter 7, article 14, section 21, from July 1, 2023, through September 30, 2023.

(b) The commissioner shall award transition child care stabilization grant amounts to all eligible programs. The transition month grant amounts must be based on the number of full-time equivalent staff who regularly care for children in the program, including employees, sole proprietors, or independent contractors. One full-time equivalent staff is defined as an individual caring for children 32 hours per week. An individual can count as more, or less, than one full-time equivalent staff, but as no more than two full-time equivalent staff.

Sec. 31. **DIRECTION TO COMMISSIONER; INCREASE FOR MAXIMUM CHILD CARE ASSISTANCE RATES.**

Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6, 6a, and 6b, the commissioner must allocate the additional basic sliding fee child care funds for calendar year 2024 to counties for updated maximum rates based on relative need to cover maximum

rate increases. In distributing the additional funds, the commissioner shall consider the following factors by county:

(1) the number of children;

(2) the provider type;

(3) the age of children served; and

(4) the amount of the increase in maximum rates.

Sec. 32. **DIRECTION TO COMMISSIONER; ALLOCATING BASIC SLIDING FEE FUNDS.**

Notwithstanding Minnesota Statutes, section 119B.03, subdivisions 6, 6a, and 6b, the commissioner of human services must allocate additional basic sliding fee child care money for calendar year 2025 to counties and Tribes to account for the change in the definition of family in Minnesota Statutes, section 119B.011, in this article. In allocating the additional money, the commissioner shall consider:

(1) the number of children in the county or Tribe who receive care from a relative custodian who accepted a transfer of permanent legal and physical custody of a child under section 260C.515, subdivision 4, or similar permanency disposition in Tribal code; successor custodian or guardian as established according to section 256N.22, subdivision 10; or foster parents in a family foster home under section 260C.007, subdivision 16b; and

(2) the average basic sliding fee cost of care in the county or Tribe.

Sec. 33. **REPEALER.**

(a) Minnesota Statutes 2022, section 119B.03, subdivision 4, is repealed.

(b) Minnesota Statutes 2022, section 245C.11, subdivision 3, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2023. Paragraph (b) is effective April 28, 2025.

ARTICLE 2
CHILD SAFETY AND PERMANENCY

Section 1. **[256.4791] INDEPENDENT LIVING SKILLS FOR FOSTER YOUTH GRANTS.**

Subdivision 1. **Program established.** The commissioner shall establish direct grants to local social service agencies, Tribes, and other organizations to provide independent living services to eligible foster youth as described under section 260C.452.

Subd. 2. **Grant awards.** The commissioner shall request proposals and make grants to eligible applicants. The commissioner shall determine the timing and form of the application and the criteria for making grant awards to eligible applicants.

Subd. 3. **Program reporting.** Grant recipients shall provide the commissioner with a report that describes all of the activities and outcomes of services funded by the grant program in a format and at a time determined by the commissioner.

Subd. 4. **Undistributed funds.** Undistributed funds must be reallocated by the commissioner for the goals of the grant process. Undistributed funds are available until expended.

Sec. 2. **[256.4792] SUPPORT BEYOND 21 GRANT PROGRAM.**

Subdivision 1. **Establishment and authority.** The commissioner shall establish grants to one or more community-based organizations to provide services and financial support to youth eligible for the support beyond 21 program under section 260C.451, subdivision 8b.

Subd. 2. **Distribution of funds by the grantee.** (a) The grantee shall distribute support beyond 21 grant program funds to eligible youth to be used for basic well-being needs and housing as determined solely by the youth.

(b) The grantee shall distribute support beyond 21 grant funds on a monthly basis for 12 months.

(c) Once a youth has completed the program, the youth must receive a stipend to complete an exit survey on their experiences in the program.

(d) A grantee may not deny funding to a youth based on any criteria beyond a youth's eligibility for the support beyond 21 program under section 260C.451, subdivision 8b.

Subd. 3. **Reporting.** The selected grantee must report quarterly to the commissioner of human services in order to receive the quarterly payment. Information to be reported includes:

(1) a list of eligible youth who have been referred;

(2) the amount of funds that have been distributed to each youth per month;

(3) any surveys completed by youth leaving the support beyond 21 program; and

(4) other data as determined by the commissioner.

Sec. 3. **[256K.47] MINOR CONNECT GRANT PROGRAM.**

Subdivision 1. **Grant program established.** The commissioner of human services shall establish a grant program for the development, implementation, and evaluation of services to increase housing stability for unaccompanied minors who are experiencing homelessness or who are at risk of homelessness and not currently receiving child welfare services.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section and have the meanings given.

(b) "Child welfare services" means services provided to children by a local social services agency or a Tribal social services agency.

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

(d) "Community-based provider" means an organization that provides services to unaccompanied minors who are experiencing homelessness or who are at risk of homelessness.

(e) "Local social services agency" means a local agency under the authority of a county welfare or human services board or county board of commissioners that is responsible for human services.

(f) "Tribal social services agency" means the unit under the authority of the governing body of a federally recognized Indian Tribe in Minnesota that is responsible for human services.

(g) "Unaccompanied minor" means a person 17 years of age or younger who is alone without the person's parent or guardian.

Subd. 3. **Grant eligibility and uses.** (a) Eligible applicants include local social services agencies, Tribal social services agencies, and community-based providers.

(b) The commissioner must award grants to eligible applicants for the development, implementation, and evaluation of activities and services that increase housing stability for

unaccompanied minors who are experiencing homelessness or who are at risk of homelessness and not currently receiving child welfare services. Eligible uses of grant money include:

(1) identifying and addressing structural factors that contribute to unaccompanied minors who are experiencing homelessness or who are being at risk of homelessness;

(2) identifying and implementing strategies to reduce racial disparities in service delivery and outcomes for unaccompanied minors who are experiencing homelessness or who are at risk of homelessness;

(3) providing culturally appropriate services that increase housing stability to an unaccompanied minor. Culturally appropriate services must be based on the minor's cultural values, beliefs, and practices and the cultural values, beliefs, and practices of the minor's family, community, and Tribe;

(4) using placement and reunification strategies to maintain and support an unaccompanied minor's relationships with the minor's parents, siblings, children, kin, significant others, and Tribe; and

(5) supporting an unaccompanied minor and the minor's family in the minor's community to safely avoid entering the child welfare system whenever possible.

(c) The commissioner may give priority to grants that involve collaboration between local social services agencies, Tribal social services agencies, and community-based providers.

Subd. 4. **Reporting.** Local social services agencies, Tribal social services agencies and community-based agencies must report quarterly to the commissioner:

(1) the number and identity of unaccompanied minors that the agencies serve who are experiencing homelessness or who are at risk of homelessness;

(2) the actions that the agency has taken to increase housing stability for unaccompanied minors who are experiencing homelessness or who are at risk of homelessness;

(3) any patterns identified by the agency that contribute to a lack of housing stability for unaccompanied minors who are experiencing homelessness or who are at risk of homelessness; and

(4) the changes needed in the community to prevent unaccompanied minors from experiencing homelessness or being at risk of homelessness.

Sec. 4. **[260.014] FAMILY FIRST PREVENTION AND EARLY INTERVENTION ALLOCATION PROGRAM.**

Subdivision 1. **Authorization.** The commissioner shall establish a program that allocates money to counties and federally recognized Tribes in Minnesota to provide prevention and early intervention services under the Family First Prevention Services Act in Public Law 115-123.

Subd. 2. **Uses.** (a) Money allocated to counties and Tribes may be used for the following purposes:

(1) to implement or expand any service or program that is included in the state's prevention plan;

(2) to implement or expand any proposed service or program;

(3) to implement or expand any existing service or programming; and

(4) any other use approved by the commissioner.

A county or a Tribe must use at least ten percent of the allocation to provide services and supports directly to families.

Subd. 3. **Payments.** (a) The commissioner shall allocate state funds appropriated under this section to each county board or Tribe on a calendar-year basis using a formula established by the commissioner.

(b) Notwithstanding this subdivision, to the extent that money is available, no county or Tribe shall be allocated less than:

(1) $25,000 in calendar year 2024;

(2) $50,000 in calendar year 2025; and

(3) $75,000 in calendar year 2026 and each year thereafter.

(c) A county agency or an initiative Tribe must submit a plan and report the use of money as determined by the commissioner.

(d) The commissioner may distribute money under this section for a two-year period.

Subd. 4. **Prohibition on supplanting existing funds.** Funds received under this section must be used to address prevention and early intervention staffing, programming, and other activities as determined by the commissioner. Funds must not be used to supplant current county or Tribal expenditures for these purposes.

Sec. 5. Minnesota Statutes 2022, section 260.761, subdivision 2, is amended to read:

Subd. 2. **Agency and court notice to tribes.** (a) When a local social services agency has information that a family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment being conducted may involve an Indian child, the local social services agency shall notify the Indian child's tribe of the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment according to section 260E.18. The local social services agency shall provide initial notice ~~shall be provided~~ by telephone and by email or facsimile. The local social services agency shall request that the tribe or a designated tribal representative participate in evaluating the family circumstances, identifying family and tribal community resources, and developing case plans.

(b) When a local social services agency has information that a child receiving services may be an Indian child, the local social services agency shall notify the tribe by telephone and by email or facsimile of the child's full name and date of birth, the full names and dates of birth of the child's biological parents, and, if known, the full names and dates of birth of the child's grandparents and of the child's Indian custodian. This notification must be provided ~~so~~ for the tribe ~~can~~ to determine if the child is enrolled in the tribe or eligible for Tribal membership, and ~~must be provided~~ the agency must provide this notification to the Tribe within seven days of receiving information that the child may be an Indian child. If information regarding the child's grandparents or Indian custodian is not available within the seven-day period, the local social services agency shall continue to request this information and shall notify the tribe when it is received. Notice shall be provided to all tribes to which the child may have any tribal lineage. If the identity or location of the child's parent or Indian custodian and tribe cannot be determined, the local social services agency shall provide the notice required in this paragraph to the United States secretary of the interior.

(c) In accordance with sections 260C.151 and 260C.152, when a court has reason to believe that a child placed in emergency protective care is an Indian child, the court administrator or a designee shall, as soon as possible and before a hearing takes place, notify the tribal social services agency by telephone and by email or facsimile of the date, time, and location of the emergency protective case hearing. The court shall make efforts to allow appearances by telephone for tribal representatives, parents, and Indian custodians.

(d) A local social services agency must provide the notices required under this subdivision at the earliest possible time to facilitate involvement of the Indian child's tribe. Nothing in this subdivision is intended to hinder the ability of the local social services agency and the court to respond to an emergency situation. Lack of participation by a tribe shall not prevent

the tribe from intervening in services and proceedings at a later date. A tribe may participate in a case at any time. At any stage of the local social services agency's involvement with an Indian child, the agency shall provide full cooperation to the tribal social services agency, including disclosure of all data concerning the Indian child. Nothing in this subdivision relieves the local social services agency of satisfying the notice requirements in the Indian Child Welfare Act.

Sec. 6. **[260.786] CHILD WELFARE STAFF ALLOCATION FOR TRIBES.**

Subdivision 1. **Allocations.** The commissioner shall allocate $80,000 annually to each of Minnesota's federally recognized Tribes that, at the beginning of the fiscal year, have not joined the American Indian Child welfare initiative under section 256.01, subdivision 14b. Tribes not participating in the initiative are: Bois Fort Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Lower Sioux Indian Community, Prairie Island Indian Community, and Upper Sioux Indian Community.

Subd. 2. **Purposes.** Funds must be used to address staffing for child protection or child welfare services. Funds must not be used to supplant current Tribal expenditures for these purposes.

Subd. 3. **Reporting.** By June 1 each year, Tribes receiving these funds shall provide a report to the commissioner. The report shall be written in a manner prescribed by the commissioner and must include an accounting of funds spent, staff hired, job duties, and other information as required by the commissioner.

Subd. 4. **Redistribution of funds.** If a Tribe joins the American Indian child welfare initiative, the payment for that Tribe shall be distributed equally among the remaining Tribes receiving an allocation under this section.

Sec. 7. Minnesota Statutes 2022, section 260C.007, subdivision 14, is amended to read:

Subd. 14. **Egregious harm.** "Egregious harm" means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. The egregious harm need not have occurred in the state or in the county where a termination of parental rights action ~~is otherwise properly venued~~ has proper venue. Egregious harm includes, but is not limited to:

(1) conduct ~~towards~~ toward a child that constitutes a violation of sections 609.185 to 609.2114, 609.222, subdivision 2, 609.223, or any other similar law of any other state;

(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;

(3) conduct ~~towards~~ toward a child that constitutes felony malicious punishment of a child under section 609.377;

(4) conduct ~~towards~~ toward a child that constitutes felony unreasonable restraint of a child under section 609.255, subdivision 3;

(5) conduct ~~towards~~ toward a child that constitutes felony neglect or endangerment of a child under section 609.378;

(6) conduct ~~towards~~ toward a child that constitutes assault under section 609.221, 609.222, or 609.223;

(7) conduct ~~towards~~ toward a child that constitutes sex trafficking, solicitation, inducement, ~~or~~ promotion of, or receiving profit derived from prostitution under section 609.322;

(8) conduct ~~towards~~ toward a child that constitutes murder or voluntary manslaughter as defined by United States Code, title 18, section 1111(a) or 1112(a);

(9) conduct ~~towards~~ toward a child that constitutes aiding or abetting, attempting, conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a violation of United States Code, title 18, section 1111(a) or 1112(a); or

(10) conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345 or sexual extortion under section 609.3458.

Sec. 8. Minnesota Statutes 2022, section 260C.451, is amended by adding a subdivision to read:

Subd. 8a. **Transition planing.** (a) For a youth who will be discharged from foster care at 21 years of age or older, the responsible social services agency must develop an individual transition plan as directed by the youth during the 180-day period immediately prior to the youth's expected date of discharge according to section 260C.452, subdivision 4. The youth's individual transition plan may be shared with a contracted agency providing case management services to the youth under section 260C.452.

(b) As part of transition planning, the responsible social services agency must inform a youth preparing to leave extended foster care of the youth's eligibility for the support beyond 21 program under subdivision 8b and must include that program in the individual transition plan for the eligible youth. Consistent with section 13.46, the local social services agency

or initiative Tribe must refer a youth to the support beyond 21 program by providing the program with the youth's contact information

Sec. 9. Minnesota Statutes 2022, section 260C.451, is amended by adding a subdivision to read:

Subd. 8b. **Support beyond 21 program.** (a) The commissioner shall establish the support beyond 21 program to provide financial assistance to a youth leaving foster care to help ensure that the youth's basic needs are met as the youth transitions into adulthood.

(b) An individual who has left extended foster care and was discharged at the age of 21 under subdivision 3 is eligible for the support beyond 21 program.

(c) An eligible youth receiving benefits under the support beyond 21 program is also eligible for the successful transition to adulthood program under section 260C.452.

(d) A youth who transitions to adult residential services under section 256B.092 or 256B.49 or a youth in a correctional facility licensed under section 241.021 is not eligible for the support beyond 21 program.

(e) To the extent that funds are available under section 256.4791, an eligible youth who participates in the support beyond 21 program must receive monthly financial assistance for 12 months after the youth is discharged from extended foster care under subdivision 3. The funds are available to assist the youth in meeting basic well-being and housing needs as determined solely by the youth. Monthly payments must be reduced quarterly. Payments must be made by a grantee according to the requirements of section 256.4791.

Sec. 10. Minnesota Statutes 2022, section 260C.452, is amended by adding a subdivision to read:

Subd. 6. **Independent living skills grant program.** (a) The commissioner shall establish direct grants to local social service agencies, Tribes, and other community organizations to provide independent living services to eligible youth under this section.

(b)The commissioner shall make allocations, request proposals, and specify the information and criteria required for applications to the independent living skills grant program.

Sec. 11. Minnesota Statutes 2022, section 260C.605, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** (a) Reasonable efforts to finalize the adoption of a child under the guardianship of the commissioner shall be made by the responsible social services

agency responsible for permanency planning for the child. The responsible social services agency's reasonable efforts to finalize the adoption of a child under the guardianship of the commissioner of human services must be subject to supervision by the commissioner pursuant to section 393.07.

(b) Reasonable efforts to make a placement in a home according to the placement considerations under section 260C.212, subdivision 2, with a relative or foster parent who will commit to being the permanent resource for the child in the event the child cannot be reunified with a parent are required under section 260.012 and may be made concurrently with reasonable, or if the child is an Indian child, active efforts to reunify the child with the parent.

(c) Reasonable efforts under paragraph (b) must begin as soon as possible when the child is in foster care under this chapter, but not later than the hearing required under section 260C.204.

(d) Reasonable efforts to finalize the adoption of the child include:

(1) considering the child's preference for an adoptive family;

(2) using age-appropriate engagement strategies to plan for adoption with the child;

(3) identifying an appropriate prospective adoptive parent for the child by updating the child's identified needs using the factors in section 260C.212, subdivision 2;

(4) making an adoptive placement that meets the child's needs by:

(i) completing or updating the relative search required under section 260C.221 and giving notice of the need for an adoptive home for the child to:

(A) relatives who have kept the agency or the court apprised of their whereabouts; or

(B) relatives of the child who are located in an updated search;

(ii) an updated search is required whenever:

(A) there is no identified prospective adoptive placement for the child notwithstanding a finding by the court that the agency made diligent efforts under section 260C.221, in a hearing required under section 260C.202;

(B) the child is removed from the home of an adopting parent; or

(C) the court determines that a relative search by the agency is in the best interests of the child;

(iii) engaging the child's relatives or current or former foster parents to commit to being the prospective adoptive parent of the child, and considering the child's relatives for adoptive placement of the child in the order specified under section 260C.212, subdivision 2, paragraph (a); or

(iv) when there is no identified prospective adoptive parent:

(A) registering the child on the state adoption exchange as required in section 259.75 unless the agency documents to the court an exception to placing the child on the state adoption exchange reported to the commissioner;

(B) reviewing all families with approved adoption home studies associated with the responsible social services agency;

(C) presenting the child to adoption agencies and adoption personnel who may assist with finding an adoptive home for the child;

(D) using newspapers and other media to promote the particular child;

(E) using a private agency under grant contract with the commissioner to provide adoption services for intensive child-specific recruitment efforts; and

(F) making any other efforts or using any other resources reasonably calculated to identify a prospective adoption parent for the child;

(5) updating and completing the social and medical history required under sections 260C.212, subdivision 15, and 260C.609;

(6) making, and keeping updated, appropriate referrals required by section 260.851, the Interstate Compact on the Placement of Children;

(7) giving notice regarding the responsibilities of an adoptive parent to any prospective adoptive parent as required under section 259.35;

(8) offering the adopting parent the opportunity to apply for or decline adoption assistance under chapter 256N;

(9) certifying the child for adoption assistance, assessing the amount of adoption assistance, and ascertaining the status of the commissioner's decision on the level of payment if the adopting parent has applied for adoption assistance;

(10) placing the child with siblings. If the child is not placed with siblings, the agency must document reasonable efforts to place the siblings together, as well as the reason for separation. The agency may not cease reasonable efforts to place siblings together for final

adoption until the court finds further reasonable efforts would be futile or that placement together for purposes of adoption is not in the best interests of one of the siblings; and

(11) working with the adopting parent to file a petition to adopt the child and with the court administrator to obtain a timely hearing to finalize the adoption.

Sec. 12. Minnesota Statutes 2022, section 260C.605, is amended by adding a subdivision to read:

Subd. 3. **Quality assurance of recruitment efforts.** The commissioner of human services shall establish an ongoing quality assurance process for recruitment efforts to monitor service integrity, including practice standards and training, consumer surveys, and random reviews of documentation.

Sec. 13. Minnesota Statutes 2022, section 260C.704, is amended to read:

260C.704 REQUIREMENTS FOR THE QUALIFIED INDIVIDUAL'S ASSESSMENT OF THE CHILD FOR PLACEMENT IN A QUALIFIED RESIDENTIAL TREATMENT PROGRAM.

(a) A qualified individual must complete an assessment of the child prior to the child's placement in a qualified residential treatment program in a format approved by the commissioner of human services unless, due to a crisis, the child must immediately be placed in a qualified residential treatment program. When a child must immediately be placed in a qualified residential treatment program without an assessment, the qualified individual must complete the child's assessment within 30 days of the child's placement. The qualified individual must:

(1) assess the child's needs and strengths, using an age-appropriate, evidence-based, validated, functional assessment approved by the commissioner of human services;

(2) determine whether the child's needs can be met by the child's family members or through placement in a family foster home; or, if not, determine which residential setting would provide the child with the most effective and appropriate level of care to the child in the least restrictive environment;

(3) develop a list of short- and long-term mental and behavioral health goals for the child; and

(4) work with the child's family and permanency team using culturally competent practices.

If a level of care determination was conducted under section 245.4885, that information must be shared with the qualified individual and the juvenile treatment screening team.

(b) The child and the child's parents, when appropriate, may request that a specific culturally competent qualified individual complete the child's assessment. The agency shall make efforts to refer the child to the identified qualified individual to complete the assessment. The assessment must not be delayed for a specific qualified individual to complete the assessment.

(c) The qualified individual must provide the assessment, when complete, to the responsible social services agency. If the assessment recommends placement of the child in a qualified residential treatment facility, the agency must distribute the assessment to the child's parent or legal guardian and file the assessment with the court report as required in section 260C.71, subdivision 2. If the assessment does not recommend placement in a qualified residential treatment facility, the agency must provide a copy of the assessment to the parents or legal guardians and the guardian ad litem and file the assessment determination with the court at the next required hearing as required in section 260C.71, subdivision 5. If court rules and chapter 13 permit disclosure of the results of the child's assessment, the agency may share the results of the child's assessment with the child's foster care provider, other members of the child's family, and the family and permanency team. The agency must not share the child's private medical data with the family and permanency team unless: (1) chapter 13 permits the agency to disclose the child's private medical data to the family and permanency team; or (2) the child's parent has authorized the agency to disclose the child's private medical data to the family and permanency team.

(d) For an Indian child, the assessment of the child must follow the order of placement preferences in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1915.

(e) In the assessment determination, the qualified individual must specify in writing:

(1) the reasons why the child's needs cannot be met by the child's family or in a family foster home. A shortage of family foster homes is not an acceptable reason for determining that a family foster home cannot meet a child's needs;

(2) why the recommended placement in a qualified residential treatment program will provide the child with the most effective and appropriate level of care to meet the child's needs in the least restrictive environment possible and how placing the child at the treatment program is consistent with the short-term and long-term goals of the child's permanency plan; and

(3) if the qualified individual's placement recommendation is not the placement setting that the parent, family and permanency team, child, or tribe prefer, the qualified individual must identify the reasons why the qualified individual does not recommend the parent's, family and permanency team's, child's, or tribe's placement preferences. The out-of-home placement plan under section 260C.708 must also include reasons why the qualified individual did not recommend the preferences of the parents, family and permanency team, child, or tribe.

(f) If the qualified individual determines that the child's family or a family foster home or other less restrictive placement may meet the child's needs, the agency must move the child out of the qualified residential treatment program and transition the child to a less restrictive setting within 30 days of the determination. If the responsible social services agency has placement authority of the child, the agency must make a plan for the child's placement according to section 260C.212, subdivision 2. The agency must file the child's assessment determination with the court at the next required hearing.

(g) If the qualified individual recommends placing the child in a qualified residential treatment program and if the responsible social services agency has placement authority of the child, the agency shall make referrals to appropriate qualified residential treatment programs and, upon acceptance by an appropriate program, place the child in an approved or certified qualified residential treatment program.

(h) The commissioner shall establish a review process for a qualified individual's completed assessment of a child. The review process must be developed with county and Tribal agency representatives. The review process must ensure that the qualified individual's assessment is an independent, objective assessment that recommends the least restrictive setting to meet the child's needs.

Sec. 14. Minnesota Statutes 2022, section 260E.01, is amended to read:

260E.01 POLICY.

(a) The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment. While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so. When this occurs, the health and safety of the children must be of paramount concern. Intervention and prevention efforts must address immediate concerns for child safety and the ongoing risk of maltreatment and should engage the protective capacities of families. In furtherance of this public policy, it is the intent of the legislature under this chapter to:

(1) protect children and promote child safety;

(2) strengthen the family;

(3) make the home, school, and community safe for children by promoting responsible child care in all settings; and

(4) provide, when necessary, a safe temporary or permanent home environment for maltreated children.

(b) In addition, it is the policy of this state to:

(1) require the reporting of maltreatment of children in the home, school, and community settings;

(2) provide for ~~the~~ voluntary reporting of maltreatment of children;

(3) require an investigation when the report alleges sexual abuse or substantial child endangerment, except when the report alleges sex trafficking by a noncaregiver sex trafficker;

(4) provide a family assessment, if appropriate, when the report does not allege sexual abuse or substantial child endangerment; ~~and~~

(5) provide a noncaregiver sex trafficking assessment when the report alleges sex trafficking by a noncaregiver sex trafficker; and

(6) provide protective, family support, and family preservation services when needed in appropriate cases.

Sec. 15. Minnesota Statutes 2022, section 260E.02, subdivision 1, is amended to read:

Subdivision 1. **Establishment of team.** A county shall establish a multidisciplinary child protection team that may include, but is not ~~be~~ limited to, the director of the local welfare agency or designees, the county attorney or designees, the county sheriff or designees, representatives of health and education, representatives of mental health, representatives of agencies providing specialized services or responding to youth who experience or are at risk of experiencing sex trafficking or sexual exploitation, or other appropriate human services or community-based agencies, and parent groups. As used in this section, a "community-based agency" may include, but is not limited to, schools, social services agencies, family service and mental health collaboratives, children's advocacy centers, early childhood and family education programs, Head Start, or other agencies serving children and families. A member of the team must be designated as the lead person of the team responsible for the planning process to develop standards for the team's activities with battered women's and domestic abuse programs and services.

Sec. 16. Minnesota Statutes 2022, section 260E.03, is amended by adding a subdivision to read:

Subd. 15a. **Noncaregiver sex trafficker.** "Noncaregiver sex trafficker" means an individual who is alleged to have engaged in the act of sex trafficking a child and who is not a person responsible for the child's care, who does not have a significant relationship with the child as defined in section 609.341, and who is not a person in a current or recent position of authority as defined in section 609.341, subdivision 10.

Sec. 17. Minnesota Statutes 2022, section 260E.03, is amended by adding a subdivision to read:

Subd. 15b. **Noncaregiver sex trafficking assessment.** "Noncaregiver sex trafficking assessment" is a comprehensive assessment of child safety, the risk of subsequent child maltreatment, and strengths and needs of the child and family. The local welfare agency shall only perform a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child by someone other than the child's caregiver. A noncaregiver sex trafficking assessment does not include a determination of whether child maltreatment occurred. A noncaregiver sex trafficking assessment includes a determination of a family's need for services to address the safety of the child or children, the safety of family members, and the risk of subsequent child maltreatment.

Sec. 18. Minnesota Statutes 2022, section 260E.03, subdivision 22, is amended to read:

Subd. 22. **Substantial child endangerment.** "Substantial child endangerment" means that a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child ~~under their~~ in the person's care that constitutes any of the following:

(1) egregious harm under subdivision 5;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect under subdivision 15, paragraph (a), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) sex trafficking, solicitation, inducement, ~~and~~ or promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) sexual extortion under section 609.3458;

(10) solicitation of children to engage in sexual conduct under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(12) use of a minor in sexual performance under section 617.246; or

(13) parental behavior, status, or condition ~~that mandates that~~ requiring the county attorney to file a termination of parental rights petition under section 260C.503, subdivision 2.

Sec. 19. Minnesota Statutes 2022, section 260E.14, subdivision 2, is amended to read:

Subd. 2. **Sexual abuse.** (a) The local welfare agency is the agency responsible for investigating an allegation of sexual abuse if the alleged offender is the parent, guardian, sibling, or an individual functioning within the family unit as a person responsible for the child's care, or a person with a significant relationship to the child if that person resides in the child's household.

(b) The local welfare agency is also responsible for assessing or investigating when a child is identified as a victim of sex trafficking.

Sec. 20. Minnesota Statutes 2022, section 260E.14, subdivision 5, is amended to read:

Subd. 5. **Law enforcement.** (a) The local law enforcement agency is the agency responsible for investigating a report of maltreatment if a violation of a criminal statute is alleged.

(b) Law enforcement and the responsible agency must coordinate their investigations or assessments as required under this chapter when ~~the~~: (1) a report alleges maltreatment that is a violation of a criminal statute by a person who is a parent, guardian, sibling, person responsible for the child's care ~~functioning~~ within the family unit, or by a person who lives in the child's household and who has a significant relationship to the child~~,~~ in a setting other than a facility as defined in section 260E.03; or (2) a report alleges sex trafficking of a child.

Sec. 21. Minnesota Statutes 2022, section 260E.17, subdivision 1, is amended to read:

Subdivision 1. **Local welfare agency.** (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment ~~or~~, an investigation, or a noncaregiver sex trafficking assessment as appropriate to prevent or provide a remedy for maltreatment.

(b) The local welfare agency shall conduct an investigation when the report involves sexual abuse, except as indicated in paragraph (f), or substantial child endangerment.

(c) The local welfare agency shall begin an immediate investigation ~~if,~~ at any time when the local welfare agency is ~~using~~ responding with a family assessment ~~response,~~ and the local welfare agency determines that there is reason to believe that sexual abuse ~~or~~, substantial child endangerment, or a serious threat to the child's safety exists.

(d) The local welfare agency may conduct a family assessment for reports that do not allege sexual abuse, except as indicated in paragraph (f), or substantial child endangerment. In determining that a family assessment is appropriate, the local welfare agency may consider issues of child safety, parental cooperation, and the need for an immediate response.

(e) The local welfare agency may conduct a family assessment ~~on~~ for a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

(f) The local welfare agency shall conduct a noncaregiver sex trafficking assessment when a maltreatment report alleges sex trafficking of a child and the alleged offender is a noncaregiver sex trafficker as defined by section 260E.03, subdivision 15a.

(g) During a noncaregiver sex trafficking assessment, the local welfare agency shall initiate an immediate investigation if there is reason to believe that a child's parent, caregiver, or household member allegedly engaged in the act of sex trafficking a child or was alleged to have engaged in any conduct requiring the agency to conduct an investigation.

Sec. 22. Minnesota Statutes 2022, section 260E.18, is amended to read:

260E.18 NOTICE TO CHILD'S TRIBE.

The local welfare agency shall provide immediate notice, according to section 260.761, subdivision 2, to an Indian child's tribe when the agency has reason to believe that the family assessment ~~or~~, investigation, or noncaregiver sex trafficking assessment may involve an

Indian child. For purposes of this section, "immediate notice" means notice provided within 24 hours.

Sec. 23. Minnesota Statutes 2022, section 260E.20, subdivision 2, is amended to read:

Subd. 2. **Face-to-face contact.** (a) Upon receipt of a screened in report, the local welfare agency shall ~~conduct a~~ have face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. When it is possible and the report alleges substantial child endangerment or sexual abuse, the local welfare agency is not required to provide notice before conducting the initial face-to-face contact with the child and the child's primary caregiver.

(b) Except in a noncaregiver sex trafficking assessment, the local welfare agency shall have face-to-face contact with the child and primary caregiver ~~shall occur~~ immediately after the agency screens in a report if sexual abuse or substantial child endangerment is alleged and within five calendar days of a screened in report for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation, except in a noncaregiver sex trafficking assessment. Face-to-face contact with the child and primary caregiver in response to a report alleging sexual abuse or substantial child endangerment may be postponed for no more than five calendar days if the child is residing in a location that is confirmed to restrict contact with the alleged offender as established in guidelines issued by the commissioner, or if the local welfare agency is pursuing a court order for the child's caregiver to produce the child for questioning under section 260E.22, subdivision 5.

(c) At the initial contact with the alleged offender, the local welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation. In a noncaregiver sex trafficking assessment, the local child welfare agency is not required to inform or interview the alleged offender.

(d) The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement, except in a noncaregiver sex trafficking assessment. The alleged offender may submit supporting documentation relevant to the assessment or investigation.

Sec. 24. Minnesota Statutes 2022, section 260E.24, subdivision 2, is amended to read:

Subd. 2. **Determination after family assessment or a noncaregiver sex trafficking assessment.** After conducting a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall determine whether child protective services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment. The local welfare agency must document the information collected under section 260E.20, subdivision 3, related to the completed family assessment in the child's or family's case notes.

Sec. 25. Minnesota Statutes 2022, section 260E.24, subdivision 7, is amended to read:

Subd. 7. **Notification at conclusion of family assessment or a noncaregiver sex trafficking assessment.** Within ten working days of the conclusion of a family assessment or a noncaregiver sex trafficking assessment, the local welfare agency shall notify the parent or guardian of the child of the need for services to address child safety concerns or significant risk of subsequent maltreatment. The local welfare agency and the family may also jointly agree that family support and family preservation services are needed.

Sec. 26. Minnesota Statutes 2022, section 260E.33, subdivision 1, is amended to read:

Subdivision 1. **Following a family assessment or a noncaregiver sex trafficking assessment.** Administrative reconsideration is not applicable to a family assessment or noncaregiver sex trafficking assessment since no determination concerning maltreatment is made.

Sec. 27. Minnesota Statutes 2022, section 260E.35, subdivision 6, is amended to read:

Subd. 6. **Data retention.** (a) Notwithstanding sections 138.163 and 138.17, a record maintained or a record derived from a report of maltreatment by a local welfare agency, agency responsible for assessing or investigating the report, court services agency, or school under this chapter shall be destroyed as provided in paragraphs (b) to (e) by the responsible authority.

(b) For a report alleging maltreatment that was not accepted for an assessment or an investigation, a family assessment case, a noncaregiver sex trafficking assessment case, and a case where an investigation results in no determination of maltreatment or the need for child protective services, the record must be maintained for a period of five years after the date that the report was not accepted for assessment or investigation or the date of the final entry in the case record. A record of a report that was not accepted must contain sufficient

information to identify the subjects of the report, the nature of the alleged maltreatment, and the reasons ~~as to~~ why the report was not accepted. Records under this paragraph may not be used for employment, background checks, or purposes other than to assist in future screening decisions and risk and safety assessments.

(c) All records relating to reports that, upon investigation, indicate ~~either~~ maltreatment or a need for child protective services shall be maintained for ten years after the date of the final entry in the case record.

(d) All records regarding a report of maltreatment, including a notification of intent to interview that was received by a school under section 260E.22, subdivision 7, shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

(e) Private or confidential data released to a court services agency under subdivision 3, paragraph (d), must be destroyed by the court services agency when ordered to do so by the local welfare agency that released the data. The local welfare agency or agency responsible for assessing or investigating the report shall order destruction of the data when other records relating to the assessment or investigation are destroyed under this subdivision.

Sec. 28. **COMMUNITY RESOURCE CENTERS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply:

(b) "Commissioner" means the commissioner of human services or the commissioner's designee.

(c) "Communities and families furthest from opportunity" means any community or family that experiences inequities in accessing supports and services due to the community's or family's circumstances, including but not limited to racism, income, disability, language, gender, and geography.

(d) "Community resource center" means a community-based coordinated point of entry that provides relationship-based, culturally responsive service navigation and other supportive services for expecting and parenting families and youth.

(e) "Culturally responsive, relationship-based service navigation" means aiding families in finding services and supports that are meaningful to them in ways that are built on trust and that use cultural values, beliefs, and practices of families, communities, indigenous families, and Tribal Nations for case planning, service design, and decision-making processes.

(f) "Expecting and parenting family" means any configuration of parents, grandparents, guardians, foster parents, kinship caregivers, and youth who are pregnant or expecting or have children and youth they care for and support.

(g) "Protective factors" means conditions or attributes of individuals, families, communities, and the larger society that mitigate risk and promote the healthy development and well-being of children, youth, and families, which are strengths that help to buffer and support families.

Subd. 2. **Community resource centers established.** The commissioner in consultation with other state agencies, partners, and the Community Resource Center Advisory Council may award grants to support planning, implementation, and evaluation of community resource centers to provide relationship-based, culturally responsive service navigation, parent, family, and caregiver supports to expecting and parenting families with a focus on ensuring equitable access to programs and services that promote protective factors and support children and families.

Subd. 3. **Commissioner's duties; related infrastructure.** The commissioner in consultation with the Community Resource Center Advisory Council shall:

(1) develop a request for proposals to support community resource centers;

(2) provide outreach and technical assistance to support applicants with data or other matters pertaining to equity of access to funding;

(3) provide technical assistance to grantees including but not limited to skill building and professional development, trainings, evaluation, communities of practice, networking, and trauma informed mental health consultation;

(4) provide data collection and IT support; and

(5) provide grant coordination and management focused on promoting equity and accountability.

Subd. 4. **Grantee duties.** At a minimum, grantees shall:

(1) provide culturally responsive, relationship-based service navigation and supports for expecting and parenting families;

(2) improve community engagement and feedback loops to support continuous improvement and program planning to better promote protective factors;

(3) demonstrate community-based planning with multiple partners;

(4) develop or use an existing parent and family advisory council consisting of community members with lived expertise to advise the work of the grantee; and

(5) participate in program evaluation, data collection, and technical assistance activities.

Subd. 5. **Eligibility.** (a) Organizations eligible to receive grant funding under this section include:

(1) community-based organizations, Tribal Nations, urban Indian organizations, local and county government agencies, schools, nonprofit agencies or any cooperative of these organizations; and

(2) organizations or cooperatives supporting communities and families furthest from opportunity.

(b) Funds must not be used to supplant any state or federal funds received by any grantee.

Subd. 6. **Community Resource Center Advisory Council; establishment and duties.** (a) The commissioner in consultation with other relevant state agencies shall appoint members to the Community Resource Center Advisory Council.

(b) Membership must be demographically and geographically diverse and include:

(1) parents and family members with lived experience and who are furthest from opportunity;

(2) community-based organizations serving families furthest from opportunity;

(3) Tribal and urban American Indian representatives;

(4) county government representatives;

(5) school and school district representatives; and

(6) state partner representatives.

(b) Duties of the Community Resource Center Advisory Council shall include but are not limited to:

(1) advising the commissioner on the development and funding of a network of community resource centers;

(2) advising the commissioner on the development of a request for proposal and grant award processes;

(3) advising the commissioner on the development of program outcomes and accountability measures; and

(4) advising the commissioner on ongoing oversight and necessary support in the implementation of the community resource centers.

Subd. 7. **Grantee reporting.** Grantees must report program data and outcomes in a manner determined by the commissioner and the Community Resource Center Advisory Council.

Subd. 8. **Evaluation.** The commissioner in partnership with the Community Resource Center Advisory Council shall develop an outcome and evaluation plan. A biannual report must be developed that reflects the duties of the Community Resource Center Advisory Council in subdivision 6 and may describe outcomes and impacts related to equity, community partnerships, program and service availability, child development, family well-being, and child welfare system involvement.

Sec. 29. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FOSTER CARE FEDERAL CASH ASSISTANCE BENEFITS PRESERVATION.**

(a) The commissioner of human services must develop a plan to preserve and make available the income and resources attributable to a child in foster care to meet the best interests of the child. The plan must include recommendations on:

(1) policies for youth and caregiver access to preserved federal cash assistance benefit payments;

(2) representative payees for children in voluntary foster care for treatment pursuant to Minnesota Statutes, chapter 260D; and

(3) family preservation and reunification.

(b) For purposes of this section, "income and resources attributed to a child" means all benefits from programs administered by the Social Security Administration, including but not limited to retirement, survivors benefits, disability insurance programs, Supplemental Security Income, veterans benefits, and railroad retirement benefits.

(c) When developing the plan under this section, the commissioner shall consult or engage with:

(1) individuals or entities with experience in managing trusts and investment;

(2) individuals or entities with expertise in providing tax advice;

(3) individuals or entities with expertise in preserving assets to avoid negative impact on public assistance eligibility;

(4) other relevant state agencies;

(5) Tribal social services agencies;

(6) counties;

(7) the Children's Justice Initiative;

(8) organizations that serve and advocate for children and families in the child protection system;

(9) parents, legal custodians, foster families, and kinship caregivers, to the extent possible;

(10) youth who have been or are currently in out-of-home placement; and

(11) other relevant stakeholders.

(d) By December 15, 2023, each county shall provide the following data for fiscal years 2019 and 2021 to the commissioner in a form prescribed by the commissioner:

(1) the nonduplicated number of children in foster care in the county who received income and resources attributable to the child as defined in paragraph (b);

(2) the number of children for whom the county was the representative payee for income and resources attributable to the child; and

(3) the amount of money that the county collected from income and resources attributable to the child as the representative payee for children in the county.

(e) By January 15, 2025, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and child welfare outlining the plan developed under this section. The report must include a projected timeline for implementing the plan, estimated implementation costs, and any legislative actions that may be required to implement the plan. The report must also include data provided by counties related to the requirements for the parent or custodian of a child to reimburse a county for the cost of care, examination, or treatment in subdivision (f).

(f) By December 15, 2023, every county shall provide the commissioner of human services with the following data from fiscal years 2019, 2020, and 2021 in a form prescribed by the commissioner:

(1) the nonduplicated number of cases in which the county received payments from a parent or custodian of a child to reimburse the cost of care, examination, or treatment; and

(2) the total amount in payments that the county collected from a parent or custodian of a child to reimburse the cost of care, examination or treatment.

(g) The commissioner may contract with an individual or entity to collect and analyze financial data reported by counties in paragraphs (d) and (f).

ARTICLE 3
CHILD SUPPORT

Section 1. Minnesota Statutes 2022, section 518A.31, is amended to read:

518A.31 SOCIAL SECURITY OR VETERANS' BENEFIT PAYMENTS RECEIVED ON BEHALF OF THE CHILD.

(a) The amount of the monthly Social Security benefits or apportioned veterans' benefits provided for a joint child shall be included in the gross income of the parent on whose eligibility the benefits are based.

(b) The amount of the monthly survivors' and dependents' educational assistance provided for a joint child shall be included in the gross income of the parent on whose eligibility the benefits are based.

(c) If Social Security or apportioned veterans' benefits are provided for a joint child based on the eligibility of the obligor, and are received by the obligee as a representative payee for the child or by the child attending school, then the amount of the benefits shall also be subtracted from the obligor's net child support obligation as calculated pursuant to section 518A.34.

(d) If the survivors' and dependents' educational assistance is provided for a joint child based on the eligibility of the obligor, and is received by the obligee as a representative payee for the child or by the child attending school, then the amount of the assistance shall also be subtracted from the obligor's net child support obligation as calculated under section 518A.34.

(e) Upon a motion to modify child support, any regular or lump sum payment of Social Security or apportioned veterans' benefit received by the obligee for the benefit of the joint child based upon the obligor's disability prior to filing the motion to modify may be used to satisfy arrears that remain due for the period of time for which the benefit was received. This paragraph applies only if the derivative benefit was not considered in the guidelines calculation of the previous child support order.

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

Sec. 2. Minnesota Statutes 2022, section 518A.32, subdivision 3, is amended to read:

Subd. 3. **Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis.** A parent is not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis upon a showing by the parent that:

(1) the unemployment, underemployment, or employment on a less than full-time basis is temporary and will ultimately lead to an increase in income;

(2) the unemployment, underemployment, or employment on a less than full-time basis represents a bona fide career change that outweighs the adverse effect of that parent's diminished income on the child; ~~or~~

(3) the unemployment, underemployment, or employment on a less than full-time basis is because a parent is physically or mentally incapacitated or due to incarceration~~.~~; or

(4) a governmental agency authorized to determine eligibility for general assistance or supplemental Social Security income has determined that the individual is eligible to receive general assistance or supplemental Social Security income. Actual income earned by the parent may be considered for the purpose of calculating child support.

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

Sec. 3. Minnesota Statutes 2022, section 518A.32, subdivision 4, is amended to read:

Subd. 4. **TANF or MFIP recipient.** If the parent of a joint child is a recipient of a temporary assistance to a needy family (TANF) ~~cash~~ grant~~,~~ or comparable state-funded Minnesota family investment program (MFIP) benefits, no potential income is to be imputed to that parent.

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

Sec. 4. Minnesota Statutes 2022, section 518A.34, is amended to read:

518A.34 COMPUTATION OF CHILD SUPPORT OBLIGATIONS.

(a) To determine the presumptive child support obligation of a parent, the court shall follow the procedure set forth in this section.

(b) To determine the obligor's basic support obligation, the court shall:

(1) determine the gross income of each parent under section 518A.29;

(2) calculate the parental income for determining child support (PICS) of each parent, by subtracting from the gross income the credit, if any, for each parent's nonjoint children under section 518A.33;

(3) determine the percentage contribution of each parent to the combined PICS by dividing the combined PICS into each parent's PICS;

(4) determine the combined basic support obligation by application of the guidelines in section 518A.35;

(5) determine each parent's share of the combined basic support obligation by multiplying the percentage figure from clause (3) by the combined basic support obligation in clause (4); and

(6) apply the parenting expense adjustment formula provided in section 518A.36 to determine the obligor's basic support obligation.

(c) If the parents have split custody of joint children, child support must be calculated for each joint child as follows:

(1) the court shall determine each parent's basic support obligation under paragraph (b) and include the amount of each parent's obligation in the court order. If the basic support calculation results in each parent owing support to the other, the court shall offset the higher basic support obligation with the lower basic support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. For the purpose of the cost-of-living adjustment required under section 518A.75, the adjustment must be based on each parent's basic support obligation prior to offset. For the purposes of this paragraph, "split custody" means that there are two or more joint children and each parent has at least one joint child more than 50 percent of the time;

(2) if each parent pays all child care expenses for at least one joint child, the court shall calculate child care support for each joint child as provided in section 518A.40. The court shall determine each parent's child care support obligation and include the amount of each parent's obligation in the court order. If the child care support calculation results in each parent owing support to the other, the court shall offset the higher child care support obligation with the lower child care support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation; and

(3) if each parent pays all medical or dental insurance expenses for at least one joint child, medical support shall be calculated for each joint child as provided in section 518A.41. The court shall determine each parent's medical support obligation and include the amount

of each parent's obligation in the court order. If the medical support calculation results in each parent owing support to the other, the court shall offset the higher medical support obligation with the lower medical support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as provided in section 518A.41.

(d) The court shall determine the child care support obligation for the obligor as provided in section 518A.40.

(e) The court shall determine the medical support obligation for each parent as provided in section 518A.41. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as described in section 518A.41.

(f) The court shall determine each parent's total child support obligation by adding together each parent's basic support, child care support, and health care coverage obligations as provided in this section.

(g) If Social Security benefits or veterans' benefits are received by one parent as a representative payee for a joint child based on the other parent's eligibility, the court shall subtract the amount of benefits from the other parent's net child support obligation, if any. Any benefit received by the obligee for the benefit of the joint child based upon the obligor's disability or past earnings in any given month in excess of the child support obligation must not be treated as an arrearage payment or a future payment.

(h) The final child support order shall separately designate the amount owed for basic support, child care support, and medical support. If applicable, the court shall use the self-support adjustment and minimum support adjustment under section 518A.42 to determine the obligor's child support obligation.

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

Sec. 5. Minnesota Statutes 2022, section 518A.41, is amended to read:

518A.41 MEDICAL SUPPORT.

Subdivision 1. **Definitions.** The definitions in this subdivision apply to this chapter and chapter 518.

(a) "Health care coverage" means ~~medical, dental, or other health care benefits that are provided by one or more health plans. Health care coverage does not include any form of~~

~~public coverage~~ private health care coverage, including fee for service, health maintenance organization, preferred provider organization, and other types of private health care coverage. Health care coverage also means public health care coverage under which medical or dental services could be provided to a dependent child.

~~(b) "Health carrier" means a carrier as defined in sections 62A.011, subdivision 2, and 62L.02, subdivision 16.~~

~~(c) "Health plan"~~ (b) "Private health care coverage" means a health plan~~, other than any form of public coverage,~~ that provides medical, dental, or other health care benefits and is:

(1) provided on an individual or group basis;

(2) provided by an employer or union;

(3) purchased in the private market; ~~or~~

(4) provided through MinnesotaCare under chapter 256L; or

~~(4)~~ (5) available to a person eligible to carry insurance for the joint child, including a party's spouse or parent.

~~Health plan~~ Private health care coverage includes, but is not limited to, a health plan meeting the definition under section 62A.011, subdivision 3, except that the exclusion of coverage designed solely to provide dental or vision care under section 62A.011, subdivision 3, clause (6), does not apply to the definition of ~~health plan~~ private health care coverage under this section; a group health plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA); a self-insured plan under sections 43A.23 to 43A.317 and 471.617; and a policy, contract, or certificate issued by a community-integrated service network licensed under chapter 62N.

(c) "Public health care coverage" means health care benefits provided by any form of medical assistance under chapter 256B. Public health care coverage does not include MinnesotaCare or health plans subsidized by federal premium tax credits or federal cost-sharing reductions.

(d) "Medical support" means providing health care coverage for a joint child ~~by carrying health care coverage for the joint child or~~ by contributing to the cost of health care coverage, ~~public coverage,~~ unreimbursed ~~medical~~ health-related expenses, and uninsured ~~medical~~ health-related expenses of the joint child.

(e) "National medical support notice" means an administrative notice issued by the public authority to enforce health insurance provisions of a support order in accordance with Code

of Federal Regulations, title 45, section 303.32, in cases where the public authority provides support enforcement services.

~~(f) "Public coverage" means health care benefits provided by any form of medical assistance under chapter 256B. Public coverage does not include MinnesotaCare or health plans subsidized by federal premium tax credits or federal cost-sharing reductions.~~

~~(g)~~ (f) "Uninsured ~~medical~~ health-related expenses" means a joint child's reasonable and necessary ~~health-related~~ medical and dental expenses if the joint child is not covered by ~~a health plan or public coverage~~ private health insurance care when the expenses are incurred.

~~(h)~~ (g) "Unreimbursed ~~medical~~ health-related expenses" means a joint child's reasonable and necessary ~~health-related~~ medical and dental expenses if a joint child is covered by ~~a health plan or public coverage~~ health care coverage and ~~the plan or~~ health care coverage does not pay for the total cost of the expenses when the expenses are incurred. Unreimbursed ~~medical~~ health-related expenses do not include the cost of premiums. Unreimbursed ~~medical~~ health-related expenses include, but are not limited to, deductibles, co-payments, and expenses for orthodontia, and prescription eyeglasses and contact lenses, but not over-the-counter medications if ~~coverage is under a health plan~~ provided through health care coverage.

Subd. 2. **Order.** (a) A completed national medical support notice issued by the public authority or a court order that complies with this section is a qualified medical child support order under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a).

(b) Every order addressing child support must state:

(1) the names, last known addresses, and Social Security numbers of the parents and the joint child that is a subject of the order unless the court prohibits the inclusion of an address or Social Security number and orders the parents to provide the address and Social Security number to the administrator of the health plan;

(2) ~~if a joint child is not presently enrolled in health care coverage,~~ whether appropriate health care coverage for the joint child is available and, if so, state:

(i) the parents' responsibilities for carrying health care coverage;

(ii) the cost of premiums and how the cost is allocated between the parents; ~~and~~

(iii) the circumstances, if any, under which an obligation to provide private health care coverage for the joint child will shift from one parent to the other; and

~~(3) if appropriate health care coverage is not available for the joint child,~~ (iv) whether a contribution for ~~medical support~~ public health care coverage is required; and

~~(4)~~ (3) how unreimbursed or uninsured ~~medical~~ health-related expenses will be allocated between the parents.

Subd. 3. **Determining appropriate health care coverage.** Public health care coverage is presumed appropriate. In determining whether a parent has appropriate private health care coverage for the joint child, the court must consider the following factors:

(1) comprehensiveness of private health care coverage providing medical benefits. Dependent private health care coverage providing medical benefits is presumed comprehensive if it includes medical and hospital coverage and provides for preventive, emergency, acute, and chronic care; or if it meets the minimum essential coverage definition in United States Code, title 26, section 5000A(f). If both parents have private health care coverage providing medical benefits that is presumed comprehensive under this paragraph, the court must determine which parent's private health care coverage is more comprehensive by considering what other benefits are included in the private health care coverage;

(2) accessibility. Dependent private health care coverage is accessible if the covered joint child can obtain services from a health plan provider with reasonable effort by the parent with whom the joint child resides. Private health care coverage is presumed accessible if:

(i) primary care is available within 30 minutes or 30 miles of the joint child's residence and specialty care is available within 60 minutes or 60 miles of the joint child's residence;

(ii) the private health care coverage is available through an employer and the employee can be expected to remain employed for a reasonable amount of time; and

(iii) no preexisting conditions exist to unduly delay enrollment in private health care coverage;

(3) the joint child's special medical needs, if any; and

(4) affordability. Dependent private health care coverage is presumed affordable if ~~it is reasonable in cost. If both parents have health care coverage available for a joint child that is comparable with regard to comprehensiveness of medical benefits, accessibility, and the joint child's special needs, the least costly health care coverage is presumed to be the most appropriate health care coverage for the joint child~~ the premium to cover the marginal cost of the joint child does not exceed five percent of the parents' combined monthly PICS. A court may additionally consider high deductibles and the cost to enroll the parent if the

parent must enroll themselves in private health care coverage to access private health care coverage for the child.

Subd. 4. **Ordering health care coverage.** ~~(a) If a joint child is presently enrolled in health care coverage, the court must order that the parent who currently has the joint child enrolled continue that enrollment unless the parties agree otherwise or a party requests a change in coverage and the court determines that other health care coverage is more appropriate.~~

~~(b) If a joint child is not presently enrolled in health care coverage providing medical benefits, upon motion of a parent or the public authority, the court must determine whether one or both parents have appropriate health care coverage providing medical benefits for the joint child.~~

(a) If a joint child is presently enrolled in health care coverage, the court shall order that the parent who currently has the joint child enrolled in health care coverage continue that enrollment if the health care coverage is appropriate as defined under subdivision 3.

~~(c)~~ (b) If only one parent has appropriate health care coverage providing medical benefits available, the court must order that parent to carry the coverage for the joint child.

~~(d)~~ (c) If both parents have appropriate health care coverage providing medical benefits available, the court must order the parent with whom the joint child resides to carry the health care coverage for the joint child, unless:

(1) a party expresses a preference for private health care coverage providing medical benefits available through the parent with whom the joint child does not reside;

(2) the parent with whom the joint child does not reside is already carrying dependent private health care coverage providing medical benefits for other children and the cost of contributing to the premiums of the other parent's health care coverage would cause the parent with whom the joint child does not reside extreme hardship; or

(3) the parties agree as to which parent will carry health care coverage providing medical benefits and agree on the allocation of costs.

~~(e)~~ (d) If the exception in paragraph ~~(d)~~ (c), clause (1) or (2), applies, the court must determine which parent has the most appropriate health care coverage providing medical benefits available and order that parent to carry health care coverage for the joint child.

~~(f)~~ (e) If neither parent has appropriate health care coverage available, the court must order the parents to~~:~~

~~(1)~~ contribute toward the actual health care costs of the joint children based on a pro rata share~~; or~~.

~~(2) if the joint child is receiving any form of public coverage, the parent with whom the joint child does not reside shall contribute a monthly amount toward the actual cost of public coverage. The amount of the noncustodial parent's contribution is determined by applying the noncustodial parent's PICS to the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). If the noncustodial parent's PICS meets the eligibility requirements for MinnesotaCare, the contribution is the amount the noncustodial parent would pay for the child's premium. If the noncustodial parent's PICS exceeds the eligibility requirements, the contribution is the amount of the premium for the highest eligible income on the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). For purposes of determining the premium amount, the noncustodial parent's household size is equal to one parent plus the child or children who are the subject of the child support order. The custodial parent's obligation is determined under the requirements for public coverage as set forth in chapter 256B; or~~

~~(3) if the noncustodial parent's PICS meet the eligibility requirement for public coverage under chapter 256B or the noncustodial parent receives public assistance, the noncustodial parent must not be ordered to contribute toward the cost of public coverage.~~

~~(g)~~ (f) If neither parent has appropriate health care coverage available, the court may order the parent with whom the child resides to apply for public health care coverage for the child.

~~(h) The commissioner of human services must publish a table with the premium schedule for public coverage and update the chart for changes to the schedule by July 1 of each year.~~

~~(i)~~ (g) If a joint child is not presently enrolled in private health care coverage providing dental benefits, upon motion of a parent or the public authority, the court must determine whether one or both parents have appropriate ~~dental~~ private health care coverage providing dental benefits for the joint child, and the court may order a parent with appropriate ~~dental~~ private health care coverage providing dental benefits available to carry the health care coverage for the joint child.

~~(j)~~ (h) If a joint child is not presently enrolled in available private health care coverage providing benefits other than medical benefits or dental benefits, upon motion of a parent or the public authority, the court may determine whether ~~that other~~ private health care coverage providing other health benefits for the joint child is appropriate, and the court may

order a parent with that appropriate private health care coverage available to carry the coverage for the joint child.

Subd. 5. **Medical support costs; unreimbursed and uninsured ~~medical~~ health-related expenses.** (a) Unless otherwise agreed to by the parties and approved by the court, the court must order that the cost of private health care coverage and all unreimbursed and uninsured ~~medical~~ health-related expenses ~~under the health plan~~ be divided between the obligor and obligee based on their proportionate share of the parties' combined monthly PICS. The amount allocated for medical support is considered child support but is not subject to a cost-of-living adjustment under section 518A.75.

(b) If a party owes a ~~joint child~~ basic support obligation for a joint child and is ordered to carry private health care coverage for the joint child, and the other party is ordered to contribute to the carrying party's cost for coverage, the carrying party's ~~child~~ basic support payment must be reduced by the amount of the contributing party's contribution.

(c) If a party owes a ~~joint child~~ basic support obligation for a joint child and is ordered to contribute to the other party's cost for carrying private health care coverage for the joint child, the contributing party's child support payment must be increased by the amount of the contribution. The contribution toward private health care coverage must not be charged in any month in which the party ordered to carry private health care coverage fails to maintain private coverage.

(d) If the party ordered to carry private health care coverage for the joint child already carries dependent private health care coverage for other dependents and would incur no additional premium costs to add the joint child to the existing health care coverage, the court must not order the other party to contribute to the premium costs for health care coverage of the joint child.

(e) If a party ordered to carry private health care coverage for the joint child does not already carry dependent private health care coverage but has other dependents who may be added to the ordered health care coverage, the full premium costs of the dependent private health care coverage must be allocated between the parties in proportion to the party's share of the parties' combined monthly PICS, unless the parties agree otherwise.

(f) If a party ordered to carry private health care coverage for the joint child is required to enroll in a health plan so that the joint child can be enrolled in dependent private health care coverage under the plan, the court must allocate the costs of the dependent private health care coverage between the parties. The costs of the private health care coverage for

the party ordered to carry the health care coverage for the joint child must not be allocated between the parties.

(g) If the joint child is receiving any form of public health care coverage:

(1) the parent with whom the joint child does not reside shall contribute a monthly amount toward the actual cost of public health care coverage. The amount of the noncustodial parent's contribution is determined by applying the noncustodial parent's PICS to the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). If the noncustodial parent's PICS meets the eligibility requirements for MinnesotaCare, the contribution is the amount that the noncustodial parent would pay for the child's premium;

(2) if the noncustodial parent's PICS exceeds the eligibility requirements, the contribution is the amount of the premium for the highest eligible income on the premium scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (d). For purposes of determining the premium amount, the noncustodial parent's household size is equal to one parent plus the child or children who are the subject of the order;

(3) the custodial parent's obligation is determined under the requirements for public health care coverage in chapter 256B; or

(4) if the noncustodial parent's PICS is less than 200 percent of the federal poverty guidelines for one person or the noncustodial parent receives public assistance, the noncustodial parent must not be ordered to contribute toward the cost of public health care coverage.

(h) The commissioner of human services must publish a table for section 256L.15, subdivision 2, paragraph (d), and update the table with changes to the schedule by July 1 of each year.

Subd. 6. **Notice or court order sent to party's employer, union, or health carrier.** (a) The public authority must forward a copy of the national medical support notice or court order for private health care coverage to the party's employer within two business days after the date the party is entered into the work reporting system under section 256.998.

(b) The public authority or a party seeking to enforce an order for private health care coverage must forward a copy of the national medical support notice or court order to the obligor's employer or union, or to the health carrier under the following circumstances:

(1) the party ordered to carry private health care coverage for the joint child fails to provide written proof to the other party or the public authority, within 30 days of the effective

date of the court order, that the party has applied for private health care coverage for the joint child;

(2) the party seeking to enforce the order or the public authority gives written notice to the party ordered to carry private health care coverage for the joint child of its intent to enforce medical support. The party seeking to enforce the order or public authority must mail the written notice to the last known address of the party ordered to carry private health care coverage for the joint child; and

(3) the party ordered to carry private health care coverage for the joint child fails, within 15 days after the date on which the written notice under clause (2) was mailed, to provide written proof to the other party or the public authority that the party has applied for private health care coverage for the joint child.

(c) The public authority is not required to forward a copy of the national medical support notice or court order to the obligor's employer or union, or to the health carrier, if the court orders private health care coverage for the joint child that is not employer-based or union-based coverage.

Subd. 7. **Employer or union requirements.** (a) An employer or union must forward the national medical support notice or court order to its health plan within 20 business days after the date on the national medical support notice or after receipt of the court order.

(b) Upon determination by an employer's or union's health plan administrator that a joint child is eligible to be covered under the health plan, the employer or union and health plan must enroll the joint child as a beneficiary in the health plan, and the employer must withhold any required premiums from the income or wages of the party ordered to carry health care coverage for the joint child.

(c) If enrollment of the party ordered to carry private health care coverage for a joint child is necessary to obtain dependent private health care coverage under the plan, and the party is not enrolled in the health plan, the employer or union must enroll the party in the plan.

(d) Enrollment of dependents and, if necessary, the party ordered to carry private health care coverage for the joint child must be immediate and not dependent upon open enrollment periods. Enrollment is not subject to the underwriting policies under section 62A.048.

(e) Failure of the party ordered to carry private health care coverage for the joint child to execute any documents necessary to enroll the dependent in the health plan does not affect the obligation of the employer or union and health plan to enroll the dependent in a

plan. Information and authorization provided by the public authority, or by a party or guardian, is valid for the purposes of meeting enrollment requirements of the health plan.

(f) An employer or union that is included under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a), may not deny enrollment to the joint child or to the parent if necessary to enroll the joint child based on exclusionary clauses described in section 62A.048.

(g) A new employer or union of a party who is ordered to provide private health care coverage for a joint child must enroll the joint child in the party's health plan as required by a national medical support notice or court order.

Subd. 8. **Health plan requirements.** (a) If a health plan administrator receives a completed national medical support notice or court order, the plan administrator must notify the parties, and the public authority if the public authority provides support enforcement services, within 40 business days after the date of the notice or after receipt of the court order, of the following:

(1) whether health care coverage is available to the joint child under the terms of the health plan and, if not, the reason why health care coverage is not available;

(2) whether the joint child is covered under the health plan;

(3) the effective date of the joint child's coverage under the health plan; and

(4) what steps, if any, are required to effectuate the joint child's coverage under the health plan.

(b) If the employer or union offers more than one plan and the national medical support notice or court order does not specify the plan to be carried, the plan administrator must notify the parents and the public authority if the public authority provides support enforcement services. When there is more than one option available under the plan, the public authority, in consultation with the parent with whom the joint child resides, must promptly select from available plan options.

(c) The plan administrator must provide the parents and public authority, if the public authority provides support enforcement services, with a notice of the joint child's enrollment, description of the health care coverage, and any documents necessary to effectuate coverage.

(d) The health plan must send copies of all correspondence regarding the private health care coverage to the parents.

(e) An insured joint child's parent's signature is a valid authorization to a health plan for purposes of processing an insurance reimbursement payment to the medical services provider or to the parent, if medical services have been prepaid by that parent.

Subd. 9. **Employer or union liability.** (a) An employer or union that willfully fails to comply with the order or notice is liable for any uninsured ~~medical~~ health-related expenses incurred by the dependents while the dependents were eligible to be enrolled in the health plan and for any other premium costs incurred because the employer or union willfully failed to comply with the order or notice.

(b) An employer or union that fails to comply with the order or notice is subject to a contempt finding, a $250 civil penalty under section 518A.73, and is subject to a civil penalty of $500 to be paid to the party entitled to reimbursement or the public authority. Penalties paid to the public authority are designated for child support enforcement services.

Subd. 10. **Contesting enrollment.** (a) A party may contest a joint child's enrollment in a health plan on the limited grounds that the enrollment is improper due to mistake of fact or that the enrollment meets the requirements of section 518.145.

(b) If the party chooses to contest the enrollment, the party must do so no later than 15 days after the employer notifies the party of the enrollment by doing the following:

(1) filing a motion in district court or according to section 484.702 and the expedited child support process rules if the public authority provides support enforcement services;

(2) serving the motion on the other party and public authority if the public authority provides support enforcement services; and

(3) securing a date for the matter to be heard no later than 45 days after the notice of enrollment.

(c) The enrollment must remain in place while the party contests the enrollment.

Subd. 11. **Disenrollment; continuation of coverage; coverage options.** (a) Unless a court order provides otherwise, a child for whom a party is required to provide private health care coverage under this section must be covered as a dependent of the party until the child is emancipated, until further order of the court, or as consistent with the terms of the health care coverage.

(b) The health carrier, employer, or union may not disenroll or eliminate health care coverage for the child unless:

(1) the health carrier, employer, or union is provided satisfactory written evidence that the court order is no longer in effect;

(2) the joint child is or will be enrolled in comparable private health care coverage through another health plan that will take effect no later than the effective date of the disenrollment;

(3) the employee is no longer eligible for dependent health care coverage; or

(4) the required premium has not been paid by or on behalf of the joint child.

(c) The health plan must provide 30 days' written notice to the joint child's parents, and the public authority if the public authority provides support enforcement services, before the health plan disenrolls or eliminates the joint child's health care coverage.

(d) A joint child enrolled in private health care coverage under a qualified medical child support order, including a national medical support notice, under this section is a dependent and a qualified beneficiary under the Consolidated Omnibus Budget and Reconciliation Act of 1985 (COBRA), Public Law 99-272. Upon expiration of the order, the joint child is entitled to the opportunity to elect continued health care coverage that is available under the health plan. The employer or union must provide notice to the parties and the public authority, if it provides support services, within ten days of the termination date.

(e) If the public authority provides support enforcement services and a plan administrator reports to the public authority that there is more than one coverage option available under the health plan, the public authority, in consultation with the parent with whom the joint child resides, must promptly select health care coverage from the available options.

Subd. 12. **Spousal or former spousal coverage.** The court must require the parent with whom the joint child does not reside to provide dependent private health care coverage for the benefit of the parent with whom the joint child resides if the parent with whom the child does not reside is ordered to provide dependent private health care coverage for the parties' joint child and adding the other parent to the health care coverage results in no additional premium cost.

Subd. 13. **Disclosure of information.** (a) If the public authority provides support enforcement services, the parties must provide the public authority with the following information:

(1) information relating to dependent health care coverage ~~or public coverage~~ available for the benefit of the joint child for whom support is sought, including all information required to be included in a medical support order under this section;

(2) verification that application for court-ordered health care coverage was made within 30 days of the court's order; and

(3) the reason that a joint child is not enrolled in court-ordered health care coverage, if a joint child is not enrolled in health care coverage or subsequently loses health care coverage.

(b) Upon request from the public authority under section 256.978, an employer, union, or plan administrator, including an employer subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a), must provide the public authority the following information:

(1) information relating to dependent private health care coverage available to a party for the benefit of the joint child for whom support is sought, including all information required to be included in a medical support order under this section; and

(2) information that will enable the public authority to determine whether a health plan is appropriate for a joint child, including, but not limited to, all available plan options, any geographic service restrictions, and the location of service providers.

(c) The employer, union, or plan administrator must not release information regarding one party to the other party. The employer, union, or plan administrator must provide both parties with insurance identification cards and all necessary written information to enable the parties to utilize the insurance benefits for the covered dependent.

(d) The public authority is authorized to release to a party's employer, union, or health plan information necessary to verify availability of dependent private health care coverage, or to establish, modify, or enforce medical support.

(e) An employee must disclose to an employer if medical support is required to be withheld under this section and the employer must begin withholding according to the terms of the order and under section 518A.53. If an employee discloses an obligation to obtain private health care coverage and health care coverage is available through the employer, the employer must make all application processes known to the individual and enroll the employee and dependent in the plan.

Subd. 14. **Child support enforcement services.** The public authority must take necessary steps to establish, enforce, and modify an order for medical support if the joint child receives public assistance or a party completes an application for services from the public authority under section 518A.51.

Subd. 15. **Enforcement.** (a) Remedies available for collecting and enforcing child support apply to medical support.

(b) For the purpose of enforcement, the following are additional support:

(1) the costs of individual or group health or hospitalization coverage;

(2) dental coverage;

(3) medical costs ordered by the court to be paid by either party, including health care coverage premiums paid by the obligee because of the obligor's failure to obtain health care coverage as ordered; and

(4) liabilities established under this subdivision.

(c) A party who fails to carry court-ordered dependent private health care coverage is liable for the joint child's uninsured ~~medical~~ health-related expenses unless a court order provides otherwise. A party's failure to carry court-ordered health care coverage, or to provide other medical support as ordered, is a basis for modification of medical support under section 518A.39, subdivision 8, unless it meets the presumption in section 518A.39, subdivision 2.

(d) Payments by the health carrier or employer for services rendered to the dependents that are directed to a party not owed reimbursement must be endorsed over to and forwarded to the vendor or appropriate party or the public authority. A party retaining insurance reimbursement not owed to the party is liable for the amount of the reimbursement.

Subd. 16. **Offset.** (a) If a party is the parent with primary physical custody as defined in section 518A.26, subdivision 17, and is an obligor ordered to contribute to the other party's cost for carrying health care coverage for the joint child, the other party's child support and spousal maintenance obligations are subject to an offset under subdivision 5.

(b) The public authority, if the public authority provides child support enforcement services, may remove the offset to a party's child support obligation when:

(1) the party's court-ordered private health care coverage for the joint child terminates;

(2) the party does not enroll the joint child in other private health care coverage; and

(3) a modification motion is not pending.

The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must remove the offset effective the first day of the month following termination of the joint child's private health care coverage.

(c) The public authority, if the public authority provides child support enforcement services, may resume the offset when the party ordered to provide private health care coverage for the joint child has resumed the court-ordered private health care coverage or

enrolled the joint child in other private health care coverage. The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must resume the offset effective the first day of the month following certification that private health care coverage is in place for the joint child.

(d) A party may contest the public authority's action to remove or resume the offset to the child support obligation if the party makes a written request for a hearing within 30 days after receiving written notice. If a party makes a timely request for a hearing, the public authority must schedule a hearing and send written notice of the hearing to the parties by mail to the parties' last known addresses at least 14 days before the hearing. The hearing must be conducted in district court or in the expedited child support process if section 484.702 applies. The district court or child support magistrate must determine whether removing or resuming the offset is appropriate and, if appropriate, the effective date for the removal or resumption.

Subd. 16a. **Suspension or reinstatement of medical support contribution.** (a) If a party is the parent with primary physical custody, as defined in section 518A.26, subdivision 17, and is ordered to carry private health care coverage for the joint child but fails to carry the court-ordered private health care coverage, the public authority may suspend the medical support obligation of the other party if that party has been court-ordered to contribute to the cost of the private health care coverage carried by the parent with primary physical custody of the joint child.

(b) If the public authority provides child support enforcement services, the public authority may suspend the other party's medical support contribution toward private health care coverage when:

(1) the party's court-ordered private health care coverage for the joint child terminates;

(2) the party does not enroll the joint child in other private health care coverage; and

(3) a modification motion is not pending.

The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must remove the medical support contribution effective the first day of the month following the termination of the joint child's private health care coverage.

(c) If the public authority provides child support enforcement services, the public authority may reinstate the medical support contribution when the party ordered to provide private health care coverage for the joint child has resumed the joint child's court-ordered private

health care coverage or has enrolled the joint child in other private health care coverage. The public authority must provide notice to the parties of the action. If neither party requests a hearing, the public authority must resume the medical support contribution effective the first day of the month following certification that the joint child is enrolled in private health care coverage.

(d) A party may contest the public authority's action to suspend or reinstate the medical support contribution if the party makes a written request for a hearing within 30 days after receiving written notice. If a party makes a timely request for a hearing, the public authority must schedule a hearing and send written notice of the hearing to the parties by mail to the parties' last known addresses at least 14 days before the hearing. The hearing must be conducted in district court or in the expedited child support process if section 484.702 applies. The district court or child support magistrate must determine whether suspending or reinstating the medical support contribution is appropriate and, if appropriate, the effective date of the removal or reinstatement of the medical support contribution.

Subd. 17. **Collecting unreimbursed or uninsured ~~medical~~ health-related expenses.** (a) This subdivision and subdivision 18 apply when a court order has determined and ordered the parties' proportionate share and responsibility to contribute to unreimbursed or uninsured ~~medical~~ health-related expenses.

(b) A party requesting reimbursement of unreimbursed or uninsured ~~medical~~ health-related expenses must initiate a request to the other party within two years of the date that the requesting party incurred the unreimbursed or uninsured ~~medical~~ health-related expenses. If a court order has been signed ordering the contribution ~~towards~~ toward unreimbursed or uninsured expenses, a two-year limitations provision must be applied to any requests made on or after January 1, 2007. The provisions of this section apply retroactively to court orders signed before January 1, 2007. Requests for unreimbursed or uninsured expenses made on or after January 1, 2007, may include expenses incurred before January 1, 2007, and on or after January 1, 2005.

(c) A requesting party must mail a written notice of intent to collect the unreimbursed or uninsured ~~medical~~ health-related expenses and a copy of an affidavit of health care expenses to the other party at the other party's last known address.

(d) The written notice must include a statement that the other party has 30 days from the date the notice was mailed to (1) pay in full; (2) agree to a payment schedule; or (3) file a motion requesting a hearing to contest the amount due or to set a court-ordered monthly payment amount. If the public authority provides services, the written notice also must

include a statement that, if the other party does not respond within the 30 days, the requesting party may submit the amount due to the public authority for collection.

(e) The affidavit of health care expenses must itemize and document the joint child's unreimbursed or uninsured ~~medical~~ health-related expenses and include copies of all bills, receipts, and insurance company explanations of benefits.

(f) If the other party does not respond to the request for reimbursement within 30 days, the requesting party may commence enforcement against the other party under subdivision 18; file a motion for a court-ordered monthly payment amount under paragraph (i); or notify the public authority, if the public authority provides services, that the other party has not responded.

(g) The notice to the public authority must include: a copy of the written notice, a copy of the affidavit of health care expenses, and copies of all bills, receipts, and insurance company explanations of benefits.

(h) If noticed under paragraph (f), the public authority must serve the other party with a notice of intent to enforce unreimbursed and uninsured ~~medical~~ health-related expenses and file an affidavit of service by mail with the district court administrator. The notice must state that the other party has 14 days to (1) pay in full; or (2) file a motion to contest the amount due or to set a court-ordered monthly payment amount. The notice must also state that if there is no response within 14 days, the public authority will commence enforcement of the expenses as arrears under subdivision 18.

(i) To contest the amount due or set a court-ordered monthly payment amount, a party must file a timely motion and schedule a hearing in district court or in the expedited child support process if section 484.702 applies. The moving party must provide the other party and the public authority, if the public authority provides services, with written notice at least 14 days before the hearing by mailing notice of the hearing to the public authority and to the requesting party at the requesting party's last known address. The moving party must file the affidavit of health care expenses with the court at least five days before the hearing. The district court or child support magistrate must determine liability for the expenses and order that the liable party is subject to enforcement of the expenses as arrears under subdivision 18 or set a court-ordered monthly payment amount.

Subd. 18. **Enforcing unreimbursed or uninsured ~~medical~~ health-related expenses as arrears.** (a) Unreimbursed or uninsured ~~medical~~ health-related expenses enforced under this subdivision are collected as arrears.

(b) If the liable party is the parent with primary physical custody as defined in section 518A.26, subdivision 17, the unreimbursed or uninsured ~~medical~~ health-related expenses must be deducted from any arrears the requesting party owes the liable party. If unreimbursed or uninsured expenses remain after the deduction, the expenses must be collected as follows:

(1) If the requesting party owes a current child support obligation to the liable party, 20 percent of each payment received from the requesting party must be returned to the requesting party. The total amount returned to the requesting party each month must not exceed 20 percent of the current monthly support obligation.

(2) If the requesting party does not owe current child support or arrears, a payment agreement under section 518A.69 is required. If the liable party fails to enter into or comply with a payment agreement, the requesting party or the public authority, if the public authority provides services, may schedule a hearing to set a court-ordered payment. The requesting party or the public authority must provide the liable party with written notice of the hearing at least 14 days before the hearing.

(c) If the liable party is not the parent with primary physical custody as defined in section 518A.26, subdivision 17, the unreimbursed or uninsured ~~medical~~ health-related expenses must be deducted from any arrears the requesting party owes the liable party. If unreimbursed or uninsured expenses remain after the deduction, the expenses must be added and collected as arrears owed by the liable party.

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

Sec. 6. Minnesota Statutes 2022, section 518A.42, subdivision 1, is amended to read:

Subdivision 1. **Ability to pay.** (a) It is a rebuttable presumption that a child support order should not exceed the obligor's ability to pay. To determine the amount of child support the obligor has the ability to pay, the court shall follow the procedure set out in this section.

(b) The court shall calculate the obligor's income available for support by subtracting a monthly self-support reserve equal to 120 percent of the federal poverty guidelines for one person from the obligor's parental income for determining child support (PICS). If benefits under section 518A.31 are received by the obligee as a representative payee for a joint child or are received by the child attending school, based on the other parent's eligibility, the court shall subtract the amount of benefits from the obligor's PICS before subtracting the self-support reserve. If the obligor's income available for support calculated under this paragraph is equal to or greater than the obligor's support obligation calculated under section 518A.34, the court shall order child support under section 518A.34.

(c) If the obligor's income available for support calculated under paragraph (b) is more than the minimum support amount under subdivision 2, but less than the guideline amount under section 518A.34, then the court shall apply a reduction to the child support obligation in the following order, until the support order is equal to the obligor's income available for support:

(1) medical support obligation;

(2) child care support obligation; and

(3) basic support obligation.

(d) If the obligor's income available for support calculated under paragraph (b) is equal to or less than the minimum support amount under subdivision 2 or if the obligor's gross income is less than 120 percent of the federal poverty guidelines for one person, the minimum support amount under subdivision 2 applies.

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

Sec. 7. Minnesota Statutes 2022, section 518A.42, subdivision 3, is amended to read:

Subd. 3. **Exception.** (a) This section does not apply to an obligor who is incarcerated or is a recipient of a general assistance grant, temporary assistance for needy families (TANF) grant or comparable state-funded Minnesota family investment program (MFIP) benefits.

(b) If the court finds the obligor receives no income and completely lacks the ability to earn income, the minimum basic support amount under this subdivision does not apply.

(c) If the obligor's basic support amount is reduced below the minimum basic support amount due to the application of the parenting expense adjustment, the minimum basic support amount under this subdivision does not apply and the lesser amount is the guideline basic support.

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

Sec. 8. Minnesota Statutes 2022, section 518A.65, is amended to read:

518A.65 DRIVER'S LICENSE SUSPENSION.

(a) This paragraph is effective July 1, 2023. Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the

obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the court ~~shall~~ may order the commissioner of public safety to suspend the obligor's driver's license. The court may consider the circumstances in paragraph (i) to determine whether driver's license suspension is an appropriate remedy that is likely to induce the payment of child support. The court may consider whether driver's license suspension would have a direct harmful effect on the obligor or joint children that would make driver's license suspension an inappropriate remedy. This paragraph expires December 31, 2025.

(b) This paragraph is effective January 1, 2026. Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has a valid driver's license issued by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the court may order the commissioner of public safety to suspend the obligor's driver's license. The court may consider the circumstances in paragraph (i) to determine whether driver's license suspension is an appropriate remedy that is likely to induce the payment of child support. The court may consider whether driver's license suspension would have a direct harmful effect on the obligor or joint children that would make driver's license suspension an inappropriate remedy.

(c) The court's order must be stayed for 90 days in order to allow the obligor to execute a written payment agreement pursuant to section 518A.69. The payment agreement must be approved by either the court or the public authority responsible for child support enforcement. If the obligor has not executed or is not in compliance with a written payment agreement pursuant to section 518A.69 after the 90 days expires, the court's order becomes effective and the commissioner of public safety shall suspend the obligor's driver's license. The remedy under this section is in addition to any other enforcement remedy available to the court. An obligee may not bring a motion under this paragraph within 12 months of a denial of a previous motion under this paragraph.

~~(b)~~ (d) This paragraph is effective July 1, 2023. If a public authority responsible for child support enforcement determines that the obligor has been or may be issued a driver's license by the commissioner of public safety ~~and~~; the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times

the obligor's total monthly support and maintenance payments and not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license unless exercising administrative discretion under paragraph (i). The remedy under this section is in addition to any other enforcement remedy available to the public authority. This paragraph expires December 31, 2025.

(e) This paragraph is effective January 1, 2026. If a public authority responsible for child support enforcement determines that:

(1) the obligor has a valid driver's license issued by the commissioner of public safety;

(2) the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments;

(3) the obligor is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority; and

(4) the obligor's mailing address is known to the public authority;

then the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license unless exercising administrative discretion under paragraph (i). The remedy under this section is in addition to any other enforcement remedy available to the public authority.

~~(c)~~ (f) At least 90 days prior to notifying the commissioner of public safety according to paragraph ~~(b)~~ (d), the public authority must mail a written notice to the obligor at the obligor's last known address, that it intends to seek suspension of the obligor's driver's license and that the obligor must request a hearing within 30 days in order to contest the suspension. If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice must include information that apprises the obligor of the requirement to develop a written payment agreement that is approved by a court, a child support magistrate, or the public authority responsible for child support enforcement regarding child support, maintenance, and any arrearages in order to avoid license suspension. The notice may be served personally or by mail. If the public authority does not receive a request for a hearing within 30 days of the date of the notice,

and the obligor does not execute a written payment agreement pursuant to section 518A.69 that is approved by the public authority within 90 days of the date of the notice, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license under paragraph ~~(b)~~ (d).

~~(d)~~ (g) At a hearing requested by the obligor under paragraph ~~(c)~~ (f), and on finding that the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments, the district court or child support magistrate shall order the commissioner of public safety to suspend the obligor's driver's license or operating privileges unless:

(1) the court or child support magistrate determines that the obligor has executed and is in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority~~.~~; or

(2) the court, in its discretion, determines that driver's license suspension is unlikely to induce payment of child support or would have direct harmful effects on the obligor or joint child that makes driver's license suspension an inappropriate remedy. The court may consider the circumstances in paragraph (f) in exercising the court's discretion.

~~(e)~~ (h) An obligor whose driver's license or operating privileges are suspended may:

(1) provide proof to the public authority responsible for child support enforcement that the obligor is in compliance with all written payment agreements pursuant to section 518A.69;

(2) bring a motion for reinstatement of the driver's license. At the hearing, if the court or child support magistrate orders reinstatement of the driver's license, the court or child support magistrate must establish a written payment agreement pursuant to section 518A.69; or

(3) seek a limited license under section 171.30. A limited license issued to an obligor under section 171.30 expires 90 days after the date it is issued.

Within 15 days of the receipt of that proof or a court order, the public authority shall inform the commissioner of public safety that the obligor's driver's license or operating privileges should no longer be suspended.

(i) Prior to notifying the commissioner of public safety that an obligor's driver's license should be suspended or after an obligor's driving privileges have been suspended, the public authority responsible for child support enforcement may use administrative authority to end

the suspension process or inform the commissioner of public safety that the obligor's driving privileges should no longer be suspended under any of the following circumstances:

(1) the full amount of court-ordered payments have been received for at least one month;

(2) an income withholding notice has been sent to an employer or payor of funds;

(3) payments less than the full court-ordered amount have been received and the circumstances of the obligor demonstrate the obligor's substantial intent to comply with the order;

(4) the obligor receives public assistance;

(5) the case is being reviewed by the public authority for downward modification due to changes in the obligor's financial circumstances or a party has filed a motion to modify the child support order;

(6) the obligor no longer lives in the state and the child support case is in the process of interstate enforcement;

(7) the obligor is currently incarcerated for one week or more or is receiving in-patient treatment for physical health, mental health, chemical dependency, or other treatment. This clause applies for six months after the obligor is no longer incarcerated or receiving in-patient treatment;

(8) the obligor is temporarily or permanently disabled and unable to pay child support;

(9) the obligor has presented evidence to the public authority that the obligor needs driving privileges to maintain or obtain the obligor's employment;

(10) the obligor has not had a meaningful opportunity to pay toward arrears; and

(11) other circumstances of the obligor indicate that a temporary condition exists for which suspension of a driver's license for the nonpayment of child support is not appropriate. When considering whether driver's license suspension is appropriate, the public authority must assess: (i) whether suspension of the driver's license is likely to induce payment of child support; and (ii) whether suspension of the driver's license would have direct harmful effects on the obligor or joint children that make driver's license suspension an inappropriate remedy.

The presence of circumstances in this paragraph does not prevent the public authority from proceeding with a suspension of a driver's license.

~~(f)~~ (j) In addition to the criteria established under this section for the suspension of an obligor's driver's license, a court, a child support magistrate, or the public authority may

direct the commissioner of public safety to suspend the license of a party who has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding. Notice to an obligor of intent to suspend must be served by first class mail at the obligor's last known address. The notice must inform the obligor of the right to request a hearing. If the obligor makes a written request within ten days of the date of the hearing, a hearing must be held. At the hearing, the only issues to be considered are mistake of fact and whether the obligor received the subpoena.

~~(g)~~ (k) The license of an obligor who fails to remain in compliance with an approved written payment agreement may be suspended. Prior to suspending a license for noncompliance with an approved written payment agreement, the public authority must mail to the obligor's last known address a written notice that (1) the public authority intends to seek suspension of the obligor's driver's license under this paragraph, and (2) the obligor must request a hearing, within 30 days of the date of the notice, to contest the suspension. If, within 30 days of the date of the notice, the public authority does not receive a written request for a hearing and the obligor does not comply with an approved written payment agreement, the public authority must direct the Department of Public Safety to suspend the obligor's license under paragraph ~~(b)~~ (d). If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice may be served personally or by mail at the obligor's last known address. If the obligor appears at the hearing and the court determines that the obligor has failed to comply with an approved written payment agreement, the court or public authority shall notify the Department of Public Safety to suspend the obligor's license under paragraph ~~(b)~~ (d). If the obligor fails to appear at the hearing, the court or public authority must notify the Department of Public Safety to suspend the obligor's license under paragraph ~~(b)~~ (d).

EFFECTIVE DATE. This section is effective July 1, 2023, unless otherwise specified.

Sec. 9. Minnesota Statutes 2022, section 518A.77, is amended to read:

518A.77 GUIDELINES REVIEW.

~~(a)~~ No later than 2006 and every four years after that, the Department of Human Services must conduct a review of the child support guidelines as required under Code of Federal Regulations, title 45, section 302.56(h).

~~(b) This section expires January 1, 2032.~~

ARTICLE 4
ECONOMIC ASSISTANCE

Section 1. Minnesota Statutes 2022, section 119B.025, subdivision 4, is amended to read:

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07, subdivision 6.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying a change.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

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

Sec. 2. Minnesota Statutes 2022, section 256D.03, is amended by adding a subdivision to read:

Subd. 2b. **Budgeting and reporting.** Every county agency shall determine eligibility and calculate benefit amounts for general assistance according to chapter 256P.

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

Sec. 3. Minnesota Statutes 2022, section 256D.63, subdivision 2, is amended to read:

Subd. 2. **SNAP reporting requirements.** The commissioner of human services shall implement simplified reporting as permitted under the Food and Nutrition Act of 2008, as amended, and the SNAP regulations in Code of Federal Regulations, title 7, part 273. SNAP benefit recipient households required to report periodically shall not be required to report more often than one time every six months. ~~This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.~~

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

Sec. 4. **[256D.65] SUPPLEMENTAL NUTRITION ASSISTANCE OUTREACH PROGRAM.**

Subdivision 1. **SNAP outreach program.** The commissioner of human services shall implement a Supplemental Nutrition Assistance Program (SNAP) outreach program to inform low-income households about the availability, eligibility requirements, application procedures, and benefits of SNAP that meets the requirements of the United States Department of Agriculture.

Subd. 2. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) supervise the administration of the SNAP outreach program according to guidance provided by the United States Department of Agriculture;

(2) submit the SNAP outreach plan and budget to the United States Department of Agriculture;

(3) accept any funds provided by the federal government or other sources for SNAP outreach;

(4) administer the request-for-proposals process and establish contracts with grantees to ensure SNAP outreach services are available to inform low-income households statewide;

(5) approve budgets from grantees to ensure that activities are eligible for federal reimbursement;

(6) monitor grantees, review invoices, and reimburse grantees for allowable costs that are eligible for federal reimbursement;

(7) provide technical assistance to grantees to ensure that projects support SNAP outreach goals and project costs are eligible for federal reimbursement;

(8) work in partnership with counties, Tribal Nations, and community organizations to enhance the reach and services of a statewide SNAP outreach program; and

(9) identify and leverage eligible nonfederal funds to earn federal reimbursement for SNAP outreach.

Subd. 3. **Program funding.** (a) Grantees must submit allowable costs for approved SNAP outreach activities to the commissioner of human services in order to receive federal reimbursement.

(b) The commissioner of human services shall disburse federal reimbursement funds for allowable costs for approved SNAP outreach activities to the state agency or grantee that incurred the costs being reimbursed.

Sec. 5. Minnesota Statutes 2022, section 256E.34, subdivision 4, is amended to read:

Subd. 4. **Use of money.** At least 96 percent of the money distributed to Hunger Solutions under this section must be distributed to food shelf programs to purchase, transport, and coordinate the distribution of nutritious food to needy individuals and families. The money distributed to food shelf programs may also be used to purchase personal hygiene products, including but not limited to diapers and toilet paper. No more than four percent of the money may be expended for other expenses, such as rent, salaries, and other administrative expenses of Hunger Solutions.

Sec. 6. **[256E.341] AMERICAN INDIAN FOOD SOVEREIGNTY FUNDING PROGRAM.**

Subdivision 1. **Establishment.** The American Indian food sovereignty funding program is established to improve access and equity to food security programs within Tribal and urban American Indian communities. The program shall assist Tribal Nations and urban American Indian communities in achieving self-determination and improve collaboration and partnership building between American Indian communities and the state. The commissioner of human services shall administer the program and provide outreach, technical assistance, and program development support to increase food security for American Indians.

Subd. 2. **Distribution of funding.** (a) The commissioner shall provide funding to support food system changes and provide equitable access to existing and new methods of food support for American Indian communities. The commissioner shall determine the funding formula, timing, and form of the application for the program.

(b) Eligible recipients of funding under this section include:

(1) federally recognized American Indian Tribes or bands in Minnesota as defined in section 10.65;

(2) the American Indian Community Housing Organization;

(3) the Division of Indian Work;

(4) Department of Indian Work within the Interfaith Action of Greater Saint Paul;

(5) the Northwest Indian Community Development Center; and

(6) other entities as determined by the commissioner.

Subd. 3. **Allowable uses of funds.** Recipients shall use funds provided under this section to promote food security for American Indian communities by:

(1) planning for sustainable food systems;

(2) implementing food security programs, including but not limited to technology to facilitate no-contact or low-contact food distribution and outreach models;

(3) providing culturally relevant training for building food access;

(4) purchasing, producing, processing, transporting, storing, and coordinating the distribution of food, including culturally relevant food; and

(5) purchasing seeds, plants, equipment, or materials to preserve, procure, or grow food.

Subd. 4. **Reporting.** (a) Recipients shall report annually on the use of American Indian food sovereignty funding program money under this section to the commissioner. Each report shall include the following information:

(1) the name and location of the recipient;

(2) the amount of funding received;

(3) the use of funds; and

(4) the number of people served.

(b) The commissioner shall determine the form required for the reports and may specify additional reporting requirements.

Sec. 7. Minnesota Statutes 2022, section 256E.35, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The Minnesota family assets for independence initiative is established to provide incentives for low-income families to accrue assets for education, housing, vehicles, emergencies, and economic development purposes.

Sec. 8. Minnesota Statutes 2022, section 256E.35, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Eligible educational institution" means the following:

(1) an institution of higher education described in section 101 or 102 of the Higher Education Act of 1965; or

(2) an area vocational education school, as defined in subparagraph (C) or (D) of United States Code, title 20, chapter 44, section 2302 (3) (the Carl D. Perkins Vocational and Applied Technology Education Act), which is located within any state, as defined in United States Code, title 20, chapter 44, section 2302 (30). This clause is applicable only to the extent section 2302 is in effect on August 1, 2008.

(c) "Family asset account" means a savings account opened by a household participating in the Minnesota family assets for independence initiative.

(d) "Fiduciary organization" means:

(1) a community action agency that has obtained recognition under section 256E.31;

(2) a federal community development credit union ~~serving the seven-county metropolitan area~~; ~~or~~

(3) a women-oriented economic development agency ~~serving the seven-county metropolitan area.~~;

(4) a federally recognized Tribal Nation; or

(5) a nonprofit organization as defined under section 501(c)(3) of the Internal Revenue Code.

(e) "Financial coach" means a person who:

(1) has completed an intensive financial literacy training workshop that includes curriculum on budgeting to increase savings, debt reduction and asset building, building a good credit rating, and consumer protection;

(2) participates in ongoing statewide family assets for independence in Minnesota (FAIM) network training meetings under FAIM program supervision; and

(3) provides financial coaching to program participants under subdivision 4a.

(f) "Financial institution" means a bank, bank and trust, savings bank, savings association, or credit union, the deposits of which are insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

(g) "Household" means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.

(h) "Permissible use" means:

(1) postsecondary educational expenses at an eligible educational institution as defined in paragraph (b), including books, supplies, and equipment required for courses of instruction;

(2) acquisition costs of acquiring, constructing, or reconstructing a residence, including any usual or reasonable settlement, financing, or other closing costs;

(3) business capitalization expenses for expenditures on capital, plant, equipment, working capital, and inventory expenses of a legitimate business pursuant to a business plan approved by the fiduciary organization;

(4) acquisition costs of a principal residence within the meaning of section 1034 of the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area purchase price applicable to the residence determined according to section 143(e)(2) and (3) of the Internal Revenue Code of 1986; ~~and~~

(5) acquisition costs of a personal vehicle only if approved by the fiduciary organization~~.~~;

(6) contributions to an emergency savings account; and

(7) contributions to a Minnesota 529 savings plan.

Sec. 9. Minnesota Statutes 2022, section 256E.35, subdivision 3, is amended to read:

Subd. 3. **Grants awarded.** The commissioner shall allocate funds to participating fiduciary organizations to provide family asset services. Grant awards must be based on a plan submitted by a statewide organization representing fiduciary organizations. The statewide organization must ensure that any interested unrepresented fiduciary organization have input into the development of the plan. The plan must equitably distribute funds to achieve geographic balance and document the capacity of participating fiduciary organizations to manage the program. A portion of funds appropriated for this section may be expended on evaluation of the Minnesota family assets for independence initiative.

Sec. 10. Minnesota Statutes 2022, section 256E.35, subdivision 4a, is amended to read:

Subd. 4a. **Financial coaching.** A financial coach shall provide the following to program participants:

(1) financial education relating to budgeting, debt reduction, asset-specific training, credit building, and financial stability activities;

(2) asset-specific training related to buying a home or vehicle, acquiring postsecondary education, ~~or~~ starting or expanding a small business, saving for emergencies, or saving for a child's education; and

(3) financial stability education and training to improve and sustain financial security.

Sec. 11. Minnesota Statutes 2022, section 256E.35, subdivision 6, is amended to read:

Subd. 6. **Withdrawal; matching; permissible uses.** (a) To receive a match, a participating household must transfer funds withdrawn from a family asset account to its matching fund custodial account held by the fiscal agent, according to the family asset agreement. The fiscal agent must determine if the match request is for a permissible use consistent with the household's family asset agreement.

(b) The fiscal agent must ensure the household's custodial account contains the applicable matching funds to match the balance in the household's account, including interest, on at least a quarterly basis and at the time of an approved withdrawal. Matches must be a contribution of $3 from state grant or TANF funds for every $1 of funds withdrawn from the family asset account not to exceed a ~~$6,000~~ $12,000 lifetime limit.

(c) Notwithstanding paragraph (b), if funds are appropriated for the Federal Assets for Independence Act of 1998, and a participating fiduciary organization is awarded a grant under that act, participating households with that fiduciary organization must be provided matches as follows:

(1) from state grant and TANF funds, a matching contribution of $1.50 for every $1 of funds withdrawn from the family asset account not to exceed a ~~$3,000~~ $6,000 lifetime limit; and

(2) from nonstate funds, a matching contribution of not less than $1.50 for every $1 of funds withdrawn from the family asset account not to exceed a ~~$3,000~~ $6,000 lifetime limit.

(d) Upon receipt of transferred custodial account funds, the fiscal agent must make a direct payment to the vendor of the goods or services for the permissible use.

Sec. 12. Minnesota Statutes 2022, section 256E.35, subdivision 7, is amended to read:

Subd. 7. **Program reporting.** The fiscal agent on behalf of each fiduciary organization participating in a family assets for independence initiative must report quarterly to the commissioner of human services identifying the participants with accounts~~,~~; the number of accounts~~,~~; the amount of savings and matches for each participant's account~~,~~; the uses of the account~~, and~~; the number of businesses, homes, vehicles, and educational services paid

for with money from the account~~,~~; and the amount of contributions to Minnesota 529 savings plans and emergency savings accounts, as well as other information that may be required for the commissioner to administer the program and meet federal TANF reporting requirements.

Sec. 13. Minnesota Statutes 2022, section 256I.03, subdivision 13, is amended to read:

Subd. 13. **Prospective budgeting.** "Prospective budgeting" ~~means estimating the amount of monthly income a person will have in the payment month~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 14. Minnesota Statutes 2022, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances according to section 256P.07 ~~that affect eligibility or housing support payment amounts, other than changes in earned income, within ten days of the change~~. Recipients with countable earned income must complete a household report form ~~at least~~ once every six months according to section 256P.10. ~~If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for housing support payments. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for housing support payment effective the first day of the month the eligibility was terminated.~~

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

Sec. 15. Minnesota Statutes 2022, section 256I.06, is amended by adding a subdivision to read:

Subd. 6a. **When to terminate assistance.** An agency must terminate benefits when the assistance unit fails to submit the household report form before the end of the month in which it is due. The termination shall be effective on the first day of the month following the month in which the report was due. If the assistance unit submits the household report form within 30 days of the termination of benefits and remains eligible, benefits must be reinstated and made available retroactively for the full benefit month.

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

Sec. 16. Minnesota Statutes 2022, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 2a.

(b) For an individual with earned income under paragraph (a), prospective budgeting according to section 256P.09 must be used ~~to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported~~.

(c) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

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

Sec. 17. Minnesota Statutes 2022, section 256J.08, subdivision 71, is amended to read:

Subd. 71. **Prospective budgeting.** "Prospective budgeting" ~~means a method of determining the amount of the assistance payment in which the budget month and payment month are the same~~ has the meaning given in section 256P.01, subdivision 9.

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

Sec. 18. Minnesota Statutes 2022, section 256J.08, subdivision 79, is amended to read:

Subd. 79. **Recurring income.** "Recurring income" means a form of income which is:

(1) received periodically, and may be received irregularly when receipt can be anticipated even though the date of receipt cannot be predicted; and

(2) from the same source or of the same type that is received and budgeted in a prospective month ~~and is received in one or both of the first two retrospective months~~.

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

Sec. 19. Minnesota Statutes 2022, section 256J.21, subdivision 3, is amended to read:

Subd. 3. **Initial income test.** (a) The agency shall determine initial eligibility by considering all earned and unearned income as defined in section 256P.06. To be eligible for MFIP, the assistance unit's countable income minus the earned income disregards in paragraph (a) and section 256P.03 must be below the family wage level according to section 256J.24, subdivision 7, for that size assistance unit.

~~(a)~~ (b) The initial eligibility determination must disregard the following items:

(1) the earned income disregard as determined in section 256P.03;

(2) dependent care costs must be deducted from gross earned income for the actual amount paid for dependent care up to a maximum of $200 per month for each child less than two years of age, and $175 per month for each child two years of age and older;

(3) all payments made according to a court order for spousal support or the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support; and

(4) an allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver according to section 256J.36.

~~(b) After initial eligibility is established,~~ (c) The income test is for a six-month period. The assistance payment calculation is based on ~~the monthly income test~~ prospective budgeting according to section 256P.09.

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

Sec. 20. Minnesota Statutes 2022, section 256J.21, subdivision 4, is amended to read:

Subd. 4. **~~Monthly~~ Income test and determination of assistance payment.** ~~The county agency shall determine ongoing eligibility and the assistance payment amount according to the monthly income test.~~ To be eligible for MFIP, the result of the computations in paragraphs (a) to (e) applied to prospective budgeting must be at least $1.

(a) Apply an income disregard as defined in section 256P.03, to gross earnings and subtract this amount from the family wage level. If the difference is equal to or greater than the MFIP transitional standard, the assistance payment is equal to the MFIP transitional standard. If the difference is less than the MFIP transitional standard, the assistance payment is equal to the difference. The earned income disregard in this paragraph must be deducted every month there is earned income.

(b) All payments made according to a court order for spousal support or the support of children not living in the assistance unit's household must be disregarded from the income of the person with the legal obligation to pay support.

(c) An allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver must be made according to section 256J.36.

(d) Subtract unearned income dollar for dollar from the MFIP transitional standard to determine the assistance payment amount.

(e) When income is both earned and unearned, the amount of the assistance payment must be determined by first treating gross earned income as specified in paragraph (a). After determining the amount of the assistance payment under paragraph (a), unearned income must be subtracted from that amount dollar for dollar to determine the assistance payment amount.

~~(f) When the monthly income is greater than the MFIP transitional standard after deductions and the income will only exceed the standard for one month, the county agency must suspend the assistance payment for the payment month.~~

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

Sec. 21. Minnesota Statutes 2022, section 256J.33, subdivision 1, is amended to read:

Subdivision 1. **Determination of eligibility.** (a) A county agency must determine MFIP eligibility prospectively ~~for a payment month~~ based on ~~retrospectively~~ assessing income and the county agency's best estimate of the circumstances that will exist in the payment month.

(b) ~~Except as described in section 256J.34, subdivision 1, when prospective eligibility exists,~~ A county agency must calculate the amount of the assistance payment using ~~retrospective~~ prospective budgeting. To determine MFIP eligibility and the assistance payment amount, a county agency must apply countable income, described in sections 256P.06 and 256J.37, subdivisions 3 to ~~10~~ 9, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under sections 256J.37, subdivisions 1 to 2, and 256P.06, subdivision 1.

(c) This income must be applied to the MFIP standard of need or family wage level subject to this section and sections 256J.34 to 256J.36. Countable income as described in section 256P.06, subdivision 3, received ~~in a calendar month~~ must be applied to the needs of an assistance unit.

(d) An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit.

EFFECTIVE DATE. This section is effective March 1, 2025, except that the amendment to paragraph (b) striking "10" and inserting "9" is effective July 1, 2024.

Sec. 22. Minnesota Statutes 2022, section 256J.33, subdivision 2, is amended to read:

Subd. 2. **Prospective eligibility.** An agency must determine whether the eligibility requirements that pertain to an assistance unit, including those in sections 256J.11 to 256J.15 and 256P.02, will be met prospectively for the payment ~~month~~ period. ~~Except for the provisions in section 256J.34, subdivision 1,~~ The income test will be applied ~~retrospectively~~ prospectively.

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

Sec. 23. Minnesota Statutes 2022, section 256J.37, subdivision 3, is amended to read:

Subd. 3. **Earned income of wage, salary, and contractual employees.** The agency must include gross earned income less any disregards in the initial ~~and monthly~~ income test. Gross earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time.

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

Sec. 24. Minnesota Statutes 2022, section 256J.37, subdivision 3a, is amended to read:

Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section ~~256J.34~~ 256P.09.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to

continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment; or

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI participant.

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

Sec. 25. Minnesota Statutes 2022, section 256J.95, subdivision 19, is amended to read:

Subd. 19. **DWP overpayments and underpayments.** DWP benefits are subject to overpayments and underpayments. Anytime an overpayment or an underpayment is determined for DWP, the correction shall be calculated using prospective budgeting. Corrections shall be determined based on the policy in section ~~256J.34, subdivision 1, paragraphs (a), (b), and (c)~~ 256P.09, subdivisions 1 to 4. ATM errors must be recovered as specified in section 256P.08, subdivision 7. Cross program recoupment of overpayments cannot be assigned to or from DWP.

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

Sec. 26. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to read:

Subd. 9. **Prospective budgeting.** "Prospective budgeting" means estimating the amount of monthly income that an assistance unit will have in the payment month.

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

Sec. 27. Minnesota Statutes 2022, section 256P.02, subdivision 2, is amended to read:

Subd. 2. **Personal property limitations.** The equity value of an assistance unit's personal property listed in clauses (1) to (5) must not exceed $10,000 for applicants and participants. For purposes of this subdivision, personal property is limited to:

(1) cash;

(2) bank accounts not excluded under subdivision 4;

(3) liquid stocks and bonds that can be readily accessed without a financial penalty;

(4) vehicles not excluded under subdivision 3; and

(5) the full value of business accounts used to pay expenses not related to the business.

Sec. 28. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision to read:

Subd. 4. **Account exception.** Family asset accounts under section 256E.35 and individual development accounts authorized under the Assets for Independence Act, Title IV of the Community Opportunities, Accountability, and Training and Educational Services Human Services Reauthorization Act of 1998, Public Law 105-285, shall be excluded when determining the equity value of personal property.

Sec. 29. Minnesota Statutes 2022, section 256P.04, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

(5) spousal support and child support payments made to persons outside the household;

(6) vehicles;

(7) checking and savings accounts, including but not limited to any business accounts used to pay expenses not related to the business;

(8) inconsistent information, if related to eligibility;

(9) residence; and

(10) Social Security number~~; and~~.

~~(11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item (ix), for the intended purpose for which it was given and received.~~

(b) Applicants who are qualified noncitizens and victims of domestic violence as defined under section 256J.08, subdivision 73, clauses (8) and (9), are not required to verify the information in paragraph (a), clause (10). When a Social Security number is not provided to the agency for verification, this requirement is satisfied when each member of the

assistance unit cooperates with the procedures for verification of Social Security numbers, issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

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

Sec. 30. Minnesota Statutes 2022, section 256P.04, subdivision 8, is amended to read:

Subd. 8. **Recertification.** The agency shall recertify eligibility annually. During recertification and reporting under section 256P.10, the agency shall verify the following:

(1) income, unless excluded, including self-employment earnings;

(2) assets when the value is within $200 of the asset limit; and

(3) inconsistent information, if related to eligibility.

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

Sec. 31. Minnesota Statutes 2022, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) retirement, survivors, and disability insurance payments;

~~(ix) nonrecurring income over $60 per quarter unless the nonrecurring income is: (A) from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by: a public agency; a court; solicitations through public appeal; a federal, state, or local unit of government; or a disaster assistance organization; (C) provided as an in-kind benefit; or (D) earmarked and used for the purpose for which it was intended, subject to verification requirements under section 256P.04;~~

~~(x)~~ (ix) retirement benefits;

~~(xi)~~ (x) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii)~~ (xi) Tribal per capita payments unless excluded by federal and state law;

~~(xiii)~~ (xii) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xiv)~~ (xiii) all child support payments for programs under chapters 119B, 256D, and 256I;

~~(xv)~~ (xiv) the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J;

~~(xvi)~~ (xv) spousal support; and

~~(xvii)~~ (xvi) workers' compensation.

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

Sec. 32. Minnesota Statutes 2022, section 256P.07, subdivision 1, is amended to read:

Subdivision 1. **Exempted programs.** Participants who receive Supplemental Security Income and qualify for Minnesota supplemental aid under chapter 256D ~~and~~ or for housing support under chapter 256I ~~on the basis of eligibility for Supplemental Security Income~~ are exempt from ~~this section~~ reporting income under this chapter.

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

Sec. 33. Minnesota Statutes 2022, section 256P.07, is amended by adding a subdivision to read:

Subd. 1a. **Child care assistance programs.** Participants who qualify for child care assistance programs under chapter 119B are exempt from this section except the reporting requirements in subdivision 6.

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

Sec. 34. Minnesota Statutes 2022, section 256P.07, subdivision 2, is amended to read:

Subd. 2. **Reporting requirements.** An applicant or participant must provide information on an application and any subsequent reporting forms about the assistance unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must report changes that affect eligibility or benefits as identified in ~~subdivision~~ subdivisions 3, 4, 5, 7, 8, and 9 during the application period or by the tenth of the month following the month the assistance unit's circumstances changed. When information is not accurately reported, both an overpayment and a referral for a fraud investigation may result. When information or documentation is not provided, the receipt of any benefit may be delayed or denied, depending on the type of information required and its effect on eligibility.

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

Sec. 35. Minnesota Statutes 2022, section 256P.07, subdivision 3, is amended to read:

Subd. 3. **Changes that must be reported.** ~~An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An assistance unit must report other changes at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report:~~

~~(1) a change in earned income of $100 per month or greater with the exception of a program under chapter 119B;~~

~~(2) a change in unearned income of $50 per month or greater with the exception of a program under chapter 119B;~~

~~(3) a change in employment status and hours with the exception of a program under chapter 119B;~~

~~(4) a change in address or residence;~~

~~(5) a change in household composition with the exception of programs under chapter 256I;~~

~~(6) a receipt of a lump-sum payment with the exception of a program under chapter 119B;~~

~~(7) an increase in assets if over $9,000 with the exception of programs under chapter 119B;~~

~~(8) a change in citizenship or immigration status;~~

~~(9) a change in family status with the exception of programs under chapter 256I;~~

~~(10) a change in disability status of a unit member, with the exception of programs under chapter 119B;~~

~~(11) a new rent subsidy or a change in rent subsidy with the exception of a program under chapter 119B; and~~

~~(12) a sale, purchase, or transfer of real property with the exception of a program under chapter 119B.~~

(a) An assistance unit must report changes or anticipated changes as described in this section.

(b) An assistance unit must report:

(1) a change in eligibility for Supplemental Security Income, Retirement Survivors Disability Insurance, or another federal income support;

(2) a change in address or residence;

(3) a change in household composition with the exception of programs under chapter 256I;

(4) cash prizes and winnings according to guidance provided for the Supplemental Nutrition Assistance Program;

(5) a change in citizenship or immigration status;

(6) a change in family status with the exception of programs under chapter 256I; and

(7) a change that makes the value of the unit's assets at or above the asset limit.

(c) When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under paragraph (b) had not occurred, the agency must determine whether the agency could have issued a timely notice on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to the notice must be considered a client error overpayment under section 256P.08.

EFFECTIVE DATE. This section is effective March 1, 2025, except that the amendment striking clause (6) is effective July 1, 2024.

Sec. 36. Minnesota Statutes 2022, section 256P.07, subdivision 4, is amended to read:

Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit under chapter 256J~~, within ten days of the change,~~ must report:

(1) a pregnancy not resulting in birth when there are no other minor children; ~~and~~

(2) a change in school attendance of a parent under 20 years of age ~~or of an employed child.~~; and

(3) an individual in the household who is 18 or 19 years of age attending high school who graduates or drops out of school.

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

Sec. 37. Minnesota Statutes 2022, section 256P.07, subdivision 6, is amended to read:

Subd. 6. **Child care assistance programs-specific reporting.** (a) ~~In addition to subdivision 3,~~ An assistance unit under chapter 119B, within ten days of the change, must report:

(1) a change in a parentally responsible individual's custody schedule for any child receiving child care assistance program benefits;

(2) a permanent end in a parentally responsible individual's authorized activity; ~~and~~

(3) if the unit's family's annual included income exceeds 85 percent of the state median income, adjusted for family size.;

(4) a change in address or residence;

(5) a change in household composition;

(6) a change in citizenship or immigration status; and

(7) a change in family status.

(b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must report a change in the unit's authorized activity status.

(c) An assistance unit must notify the county when the unit wants to reduce the number of authorized hours for children in the unit.

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

Sec. 38. Minnesota Statutes 2022, section 256P.07, subdivision 7, is amended to read:

Subd. 7. **Minnesota supplemental aid-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the Minnesota supplemental aid program under ~~section 256D.44, subdivision 5, paragraph (g), within ten days of the change,~~ chapter 256D and not receiving Supplemental Security Income must report ~~shelter expenses.~~:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater.

(b) An assistance unit receiving housing assistance under section 256D.44, subdivision 5, paragraph (g), including assistance units that also receive Supplemental Security Income, must report:

(1) a change in shelter expenses; and

(2) a new rent subsidy or a change in rent subsidy.

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

Sec. 39. Minnesota Statutes 2022, section 256P.07, is amended by adding a subdivision to read:

Subd. 8. **Housing support-specific reporting.** (a) In addition to subdivision 3, an assistance unit participating in the housing support program under chapter 256I and not receiving Supplemental Security Income must report:

(1) a change in unearned income of $50 per month or greater; and

(2) a change in earned income of $100 per month or greater, unless the assistance unit is already subject to six-month reporting requirements in section 256P.10.

(b) Notwithstanding the exemptions in subdivisions 1 and 3, an assistance unit receiving housing support under chapter 256I, including an assistance unit that receives Supplemental Security Income, must report:

(1) a new rent subsidy or a change in rent subsidy;

(2) a change in the disability status of a unit member; and

(3) a change in household composition if the assistance unit is a participant in housing support under section 256I.04, subdivision 3, paragraph (a), clause (3).

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

Sec. 40. Minnesota Statutes 2022, section 256P.07, is amended by adding a subdivision to read:

Subd. 9. **General assistance-specific reporting.** In addition to subdivision 3, an assistance unit participating in the general assistance program under chapter 256D must report:

(1) a change in unearned income of $50 per month or greater;

(2) a change in earned income of $100 per month or greater, unless the assistance unit is already subject to six-month reporting requirements in section 256P.10; and

(3) changes in any condition that would result in the loss of basis for eligibility in section 256D.05, subdivision 1, paragraph (a).

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

Sec. 41. **[256P.09] PROSPECTIVE BUDGETING OF BENEFITS.**

Subdivision 1. **Exempted programs.** Assistance units that qualify for child care assistance programs under chapter 119B and assistance units that receive housing support under chapter 256I are not subject to reporting under section 256P.10, and assistance units that qualify for Minnesota supplemental aid under chapter 256D are exempt from this section.

Subd. 2. **Prospective budgeting of benefits.** An agency subject to this chapter must use prospective budgeting to calculate the assistance payment amount.

Subd. 3. **Initial income.** For the purpose of determining an assistance unit's level of benefits, an agency must take into account the income already received by the assistance unit during or anticipated to be received during the application period. Income anticipated to be received only in the initial month of eligibility must only be counted in the initial month.

Subd. 4. **Income determination.** An agency must use prospective budgeting to determine the amount of the assistance unit's benefit for the eligibility period based on the best information available at the time of approval. An agency shall only count anticipated income when the participant and the agency are reasonably certain of the amount of the payment and the month in which the payment will be received. If the exact amount of the income is not known, the agency shall consider only the amounts that can be anticipated as income.

Subd. 5. **Income changes.** An increase in income shall not affect an assistance unit's eligibility or benefit amount until the next review unless otherwise required to be reported in section 256P.07. A decrease in income shall be effective on the date that the change occurs if the change is reported by the tenth of the month following the month when the change occurred. If the assistance unit does not report the change in income by the tenth of the month following the month when the change occurred, the change in income shall be effective on the date the change was reported.

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

Sec. 42. **[256P.10] SIX-MONTH REPORTING.**

Subdivision 1. **Exempted programs.** Assistance units that qualify for child care assistance programs under chapter 119B, assistance units that qualify for Minnesota supplemental aid under chapter 256D, and assistance units that qualify for housing support under chapter 256I and also receive Supplemental Security Income are exempt from this section.

Subd. 2. **Reporting.** (a) Every six months, an assistance unit that qualifies for the Minnesota family investment program under chapter 256J, an assistance unit that qualifies for general assistance under chapter 256D with an earned income of $100 per month or greater, or an assistance unit that qualifies for housing support under chapter 256I with an earned income of $100 per month or greater is subject to six-month reviews. The initial reporting period may be shorter than six months in order to align with other programs' reporting periods.

(b) An assistance unit that qualifies for the Minnesota family investment program or an assistance unit that qualifies for general assistance with an earned income of $100 per month or greater must complete household report forms as required by the commissioner for redetermination of benefits.

(c) An assistance unit that qualifies for housing support with an earned income of $100 per month or greater must complete household report forms as prescribed by the commissioner to provide information about earned income.

(d) An assistance unit that qualifies for housing support and also receives assistance through the Minnesota family investment program shall be subject to requirements of this section for purposes of the Minnesota family investment program but not for housing support.

(e) An assistance unit covered by this section must submit a household report form in compliance with the provisions in section 256P.04, subdivision 11.

(f) An assistance unit covered by this section may choose to report changes under this section at any time.

Subd. 3. **When to terminate assistance.** (a) An agency must terminate benefits when the assistance unit fails to submit the household report form before the end of the six-month review period. If the assistance unit submits the household report form within 30 days of the termination of benefits and remains eligible, benefits must be reinstated and made available retroactively for the full benefit month.

(b) When an assistance unit is determined to be ineligible for assistance according to this section and chapter 256D, 256I, or 256J, the agency must terminate assistance.

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

Sec. 43. **APPROPRIATION; EMERGENCY FOOD DISTRIBUTION FACILITIES.**

$19,000,000 in fiscal year 2024 is appropriated from the general fund to the commissioner of human services for improving and expanding the infrastructure of food shelf facilities across the state, including adding freezer or cooler space and dry storage space, improving the safety and sanitation of existing food shelves, and addressing deferred maintenance or other facility needs of existing food shelves. Grant money shall be made available to nonprofit organizations, federally recognized Tribes, and local units of government. This is a onetime appropriation and is available until June 30, 2027.

Sec. 44. **REPEALER.**

(a) Minnesota Statutes 2022, sections 256.9864; 256J.08, subdivisions 10, 53, 61, 62, 81, and 83; 256J.30, subdivisions 5, 7, and 8; 256J.33, subdivisions 3, 4, and 5; 256J.34, subdivisions 1, 2, 3, and 4; and 256J.37, subdivision 10, are repealed.

(b) Minnesota Statutes 2022, section 256.8799, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective March 1, 2025, except the repeal of Minnesota Statutes 2022, sections 256J.08, subdivisions 62 and 53, and 256J.37, subdivision 10, is effective July 1, 2024. Paragraph (b) is effective August 1, 2023.

ARTICLE 5
ADDRESSING DEEP POVERTY

Section 1. Minnesota Statutes 2022, section 256D.01, subdivision 1a, is amended to read:

Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to provide for single adults, childless couples, or children as defined in section 256D.02, subdivision 6, ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The ~~commissioner shall set the~~ standard of assistance for an assistance unit consisting of ~~an adult~~ a recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian is the cash portion of the MFIP transitional standard for a single adult under section 256J.24, subdivision 5. ~~When the other standards specified in this subdivision increase, this standard must also be increased by the same percentage.~~

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance ~~is the amount that the aid to families with dependent children standard of assistance, in effect on July 16, 1996, would increase if the recipient were added as an additional minor child to an assistance unit consisting of the recipient's parent and all of that parent's family members, except that the standard may not exceed the standard for a general assistance recipient living alone~~ is the cash portion of the MFIP transitional standard for a single adult under section 256J.24, subdivision 5. Benefits received by a responsible relative of the assistance unit under the Supplemental Security Income program, a workers' compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the Social Security retirement program,

may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods must follow the provisions under section 256P.06.

(d) For an assistance unit consisting of a childless couple, the standards of assistance are the same as the first and second adult standards of the aid to families with dependent children program in effect on July 16, 1996. If one member of the couple is not included in the general assistance grant, the standard of assistance for the other is the second adult standard of the aid to families with dependent children program as of July 16, 1996.

Sec. 2. Minnesota Statutes 2022, section 256D.024, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) ~~If~~ An ~~applicant or recipient~~ individual who has been convicted of a felony-level drug offense ~~after July 1, 1997, the assistance unit is ineligible for benefits under this chapter until five years after the applicant has completed terms of the court-ordered sentence, unless the person is participating in a drug treatment program, has successfully completed a drug treatment program, or has been assessed by the county and determined not to be in need of a drug treatment program. Persons subject to the limitations of this subdivision who become eligible for assistance under this chapter shall~~ during the previous ten years from the date of application or recertification may be subject to random drug testing ~~as a condition of continued eligibility and shall lose eligibility for benefits for five years beginning the month following:~~. The county must provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

~~(1) Any positive test result for an illegal controlled substance; or~~

~~(2) discharge of sentence after conviction for another drug felony.~~

(b) For the purposes of this subdivision, "drug offense" means a conviction that occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification

and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

Sec. 3. Minnesota Statutes 2022, section 256D.06, subdivision 5, is amended to read:

Subd. 5. **Eligibility; requirements.** (a) Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (1) make application for those benefits within ~~30~~ 90 days of the general assistance application; and (2) execute an interim assistance agreement on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period.

(c) The commissioner may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section.

(d) The commissioner may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for people with a disability.

(e) The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.

Sec. 4. Minnesota Statutes 2022, section 256I.03, subdivision 7, is amended to read:

Subd. 7. **Countable income.** (a) "Countable income" means all income received by an applicant or recipient as described under section 256P.06, less any applicable exclusions or disregards. ~~For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is a recipient of housing support, less the medical assistance personal needs allowance under section 256B.35. If the SSI limit~~

~~or benefit is reduced for a person due to events other than receipt of additional income, countable income means actual income less any applicable exclusions and disregards.~~

(b) For a recipient of any cash benefit from the SSI program who does not live in a setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals the SSI benefit limit in effect at the time the person is a recipient of housing support, less the medical assistance personal needs allowance under section 256B.35. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income equals actual income less any applicable exclusions and disregards.

(c) For a recipient of any cash benefit from the SSI program who lives in a setting as described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30 percent of the SSI benefit limit in effect at the time a person is a recipient of housing support. If the SSI limit or benefit is reduced for a person due to events other than receipt of additional income, countable income equals 30 percent of the actual income less any applicable exclusions and disregards. For recipients under this paragraph, the medical assistance personal needs allowance described in sections 256I.04, subdivision 1, paragraph (a), clause (2), and 256I.04, subdivision 1, paragraph (b), does not apply.

(d) Notwithstanding the earned income disregard described in section 256P.03, for a recipient of unearned income as defined in section 256P.06, subdivision 3, clause (2), other than SSI who lives in a setting described in section 256I.04, subdivision 2a, paragraph (b), clause (2), countable income equals 30 percent of the recipient's total income after applicable exclusions and disregards. Total income includes any unearned income as defined in section 256P.06 and any earned income in the month the person is a recipient of housing support. For recipients under this paragraph, the medical assistance personal needs allowance described in sections 256I.04, subdivision 1, paragraph (a), clause (2), and 256I.04, subdivision 1, paragraph (b), does not apply.

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

Sec. 5. Minnesota Statutes 2022, section 256J.26, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) An individual who has been convicted of a felony level drug offense ~~committed~~ during the previous ten years from the date of application or recertification is subject to the following:

(1) Benefits for the entire assistance unit must be paid in vendor form for shelter and utilities during any time the applicant is part of the assistance unit.

(2) The convicted applicant or participant ~~shall~~ may be subject to random drug testing ~~as a condition of continued eligibility and~~. Following any positive test for an illegal controlled substance ~~is subject to the following sanctions:~~, the county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(i) for failing a drug test the first time, the residual amount of the participant's grant after making vendor payments for shelter and utility costs, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size. When a sanction under this subdivision is in effect, the job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, the job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; or~~

~~(ii) for failing a drug test two times, the participant is permanently disqualified from receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP grant must be reduced by the amount which would have otherwise been made available to the disqualified participant. Disqualification under this item does not make a participant ineligible for the Supplemental Nutrition Assistance Program (SNAP). Before a disqualification under this provision is imposed, the job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

~~(3) A participant who fails a drug test the first time and is under a sanction due to other MFIP program requirements is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction as specified under section 256J.46, subdivision 1, paragraph (d).~~

(b) Applicants requesting only SNAP benefits or participants receiving only SNAP benefits, who have been convicted of a felony-level drug offense ~~that occurred after July 1, 1997,~~ during the previous ten years from the date of application or recertification may, if otherwise eligible, receive SNAP benefits ~~if~~. The convicted applicant or participant ~~is~~ may be subject to random drug testing ~~as a condition of continued eligibility~~. Following a

positive test for an illegal controlled substance, the ~~applicant is subject to the following sanctions:~~ county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(1) for failing a drug test the first time, SNAP benefits shall be reduced by an amount equal to 30 percent of the applicable SNAP benefit allotment. When a sanction under this clause is in effect, a job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, a job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; and~~

~~(2) for failing a drug test two times, the participant is permanently disqualified from receiving SNAP benefits. Before a disqualification under this provision is imposed, a job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

(c) For the purposes of this subdivision, "drug offense" means ~~an offense~~ a conviction that occurred during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, 152.096, or 152.137. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the ~~offense~~ conviction occurred during the previous ten years from the date of application or recertification and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

Sec. 6. Minnesota Statutes 2022, section 256P.01, is amended by adding a subdivision to read:

Subd. 5a. **Lived-experience engagement.** "Lived-experience engagement" means an intentional engagement of people with lived experience by a federal, Tribal, state, county, municipal, or nonprofit human services agency funded in part or in whole by federal, state, local government, Tribal Nation, public, private, or philanthropic funds to gather and share feedback on the impact of human services programs.

Sec. 7. Minnesota Statutes 2022, section 256P.02, subdivision 2, is amended to read:

Subd. 2. **Personal property limitations.** The equity value of an assistance unit's personal property listed in clauses (1) to (5) must not exceed $10,000 for applicants and participants. For purposes of this subdivision, personal property is limited to:

(1) cash not excluded under subdivision 4;

(2) bank accounts;

(3) liquid stocks and bonds that can be readily accessed without a financial penalty;

(4) vehicles not excluded under subdivision 3; and

(5) the full value of business accounts used to pay expenses not related to the business.

Sec. 8. Minnesota Statutes 2022, section 256P.02, is amended by adding a subdivision to read:

Subd. 4. **Health and human services recipient engagement income.** Income received from lived-experience engagement, as defined in section 256P.01, subdivision 6, shall be excluded when determining the equity value of personal property.

Sec. 9. Minnesota Statutes 2022, section 256P.06, subdivision 3, is amended to read:

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income that is received by an adult member of the assistance unit unless the individual receiving unemployment insurance income is:

(A) 18 years of age and enrolled in a secondary school; or

(B) 18 or 19 years of age, a caregiver, and is enrolled in school at least half-time;

(viii) retirement, survivors, and disability insurance payments;

(ix) nonrecurring income over $60 per quarter unless the nonrecurring income is: (A) from tax refunds, tax rebates, or tax credits; (B) a reimbursement, rebate, award, grant, or refund of personal or real property or costs or losses incurred when these payments are made by: a public agency; a court; solicitations through public appeal; a federal, state, or local unit of government; or a disaster assistance organization; (C) provided as an in-kind benefit; or (D) earmarked and used for the purpose for which it was intended, subject to verification requirements under section 256P.04;

(x) retirement benefits;

(xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

~~(xii) Tribal per capita payments unless excluded by federal and state law;~~

~~(xiii)~~ (xii) income from members of the United States armed forces unless excluded from income taxes according to federal or state law;

~~(xiv)~~ (xiii) all child support payments for programs under chapters 119B, 256D, and 256I;

~~(xv)~~ (xiv) the amount of child support received that exceeds $100 for assistance units with one child and $200 for assistance units with two or more children for programs under chapter 256J;

~~(xvi)~~ (xv) spousal support; and

~~(xvii)~~ (xvi) workers' compensation.

Sec. 10. Minnesota Statutes 2022, section 256P.06, is amended by adding a subdivision to read:

Subd. 4. **Recipient engagement income.** Income received from lived-experience engagement, as defined in section 256P.01, subdivision 5a, must not be counted as income for purposes of determining or redetermining eligibility or benefits.

Sec. 11. Minnesota Statutes 2022, section 609B.425, subdivision 2, is amended to read:

Subd. 2. **Benefit eligibility.** (a) For general assistance benefits and Minnesota supplemental aid under chapter 256D, a person convicted of a felony-level drug offense ~~after July 1, 1997, is ineligible for general assistance benefits and Supplemental Security Income under chapter 256D until:~~ during the previous ten years from the date of application or recertification may be subject to random drug testing. The county must provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

~~(1) five years after completing the terms of a court-ordered sentence; or~~

~~(2) unless the person is participating in a drug treatment program, has successfully completed a program, or has been determined not to be in need of a drug treatment program.~~

~~(b) A person who becomes eligible for assistance under chapter 256D is subject to random drug testing and shall lose eligibility for benefits for five years beginning the month following:~~

~~(1) any positive test for an illegal controlled substance; or~~

~~(2) discharge of sentence for conviction of another drug felony.~~

~~(c)~~ (b) Parole violators and fleeing felons are ineligible for benefits and persons fraudulently misrepresenting eligibility are also ineligible to receive benefits for ten years.

Sec. 12. Minnesota Statutes 2022, section 609B.435, subdivision 2, is amended to read:

Subd. 2. **Drug offenders; random testing; sanctions.** A person who is an applicant for benefits from the Minnesota family investment program or MFIP, the vehicle for temporary assistance for needy families or TANF, and who has been convicted of a felony-level drug offense ~~shall~~ may be subject to ~~certain conditions, including~~ random drug testing~~, in order to receive MFIP benefits~~. Following any positive test for a controlled substance, the ~~convicted applicant or participant is subject to the following sanctions:~~ county must provide information about substance use disorder treatment programs to the applicant or participant.

~~(1) a first time drug test failure results in a reduction of benefits in an amount equal to 30 percent of the MFIP standard of need; and~~

~~(2) a second time drug test failure results in permanent disqualification from receiving MFIP assistance.~~

~~A similar disqualification sequence occurs if the applicant is receiving Supplemental Nutrition Assistance Program (SNAP) benefits.~~

ARTICLE 6
HOUSING AND HOMELESSNESS

Section 1. Minnesota Statutes 2022, section 145.4716, subdivision 3, is amended to read:

Subd. 3. **Youth eligible for services.** Youth 24 years of age or younger shall be eligible for all services, support, and programs provided under this section and section 145.4717, and all shelter, housing beds, and services provided by the commissioner of human services to sexually exploited youth and youth at risk of sexual exploitation under section 256K.47.

Sec. 2. Minnesota Statutes 2022, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), ~~or~~ (c), or (d).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date

at a setting approved for housing support following discharge from treatment, plus two full months.

(d) The individual meets the criteria related to establishing a certified disability or disabling condition in paragraph (a) or (b) and lacks a fixed, adequate, nighttime residence upon discharge from a correctional facility, as determined by an authorized representative from a Minnesota-based correctional facility. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following release, plus two full months. People who meet the disabling condition criteria established in paragraph (a) or (b) will not have any countable income for the duration of eligibility under this paragraph.

Sec. 3. Minnesota Statutes 2022, section 256K.45, subdivision 3, is amended to read:

Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and ongoing supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, sexual exploitation, substance abuse, sexually transmitted diseases, and pregnancy;

(6) referrals to other agencies that provide support services to homeless youth, youth at risk of homelessness, and runaways;

(7) assistance with education, employment, and independent living skills;

(8) aftercare services;

(9) specialized services for highly vulnerable runaways and homeless youth, including ~~teen~~ but not limited to youth at risk of discrimination based on sexual orientation or gender identity, young parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and

(10) homelessness prevention.

Sec. 4. Minnesota Statutes 2022, section 256K.45, subdivision 7, is amended to read:

Subd. 7. **Provider repair or improvement grants.** (a) Providers that serve homeless youth ~~under this section~~ may apply for a grant of up to ~~$200,000~~ $500,000 under this subdivision to make minor or mechanical repairs or improvements to a facility providing services to homeless youth or youth at risk of homelessness.

(b) Grant applications under this subdivision must include a description of the repairs or improvements and the estimated cost of the repairs or improvements.

~~(c) Grantees under this subdivision cannot receive grant funds under this subdivision for two consecutive years.~~

Sec. 5. **[256K.47] SAFE HARBOR SHELTER AND HOUSING GRANT PROGRAM.**

Subdivision 1. **Grant program established.** The commissioner of human services shall establish the safe harbor shelter and housing grant program and award grants to providers who are committed to serving sexually exploited youth and youth at risk of sexual exploitation. The grant program is to provide street and community outreach programs, emergency shelter programs, and supportive housing programs, consistent with the program descriptions in this section in order to address the specialized outreach, shelter, and housing needs of sexually exploited youth and youth at risk of sexual exploitation.

Subd. 2. **Youth eligible for services.** Youth 24 years of age or younger shall be eligible for all shelter, housing beds, and services provided under this section and all services, support, and programs provided by the commissioner of health to sexually exploited youth and youth at risk of sexual exploitation under sections 145.4716 and 145.4717.

Subd. 3. **Street and community outreach.** Street and community outreach programs receiving grants under this section must locate, contact, and provide information, referrals, and services to eligible youth. Information, referrals, and services provided by street and community outreach programs may include but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, sexual exploitation, substance use, sexually transmitted infections, and pregnancy;

(6) referrals to other agencies that provide support services to sexually exploited youth and youth at risk of sexual exploitation;

(7) assistance with education, employment, and independent living skills;

(8) aftercare services;

(9) specialized services for sexually exploited youth and youth at risk of sexual exploitation, including youth experiencing homelessness and youth with mental health needs; and

(10) services to address the prevention of sexual exploitation and homelessness.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide eligible youth with referral and walk-in access to emergency, short-term residential care. The program shall provide eligible youth with safe, dignified shelter, including private shower facilities, beds, and meals each day; and shall assist eligible youth with reunification with the family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include but are not limited to:

(1) specialized services to address the trauma of sexual exploitation;

(2) family reunification services;

(3) individual, family, and group counseling;

(4) assistance obtaining clothing;

(5) access to medical and dental care and mental health counseling;

(6) counseling regarding violence, sexual exploitation, substance use, sexually transmitted infections, and pregnancy;

(7) education and employment services;

(8) recreational activities;

(9) advocacy and referral services;

(10) independent living skills training;

(11) aftercare and follow-up services;

(12) transportation; and

(13) services to address the prevention of sexual exploitation and homelessness.

Subd. 5. **Supportive housing programs.** Supportive housing programs must help eligible youth find and maintain safe, dignified housing and provide related supportive services and referrals. The program may also provide rental assistance. Services provided in supportive housing programs may include but are not limited to:

(1) specialized services to address the trauma of sexual exploitation;

(2) education and employment services;

(3) budgeting and money management;

(4) assistance in securing housing appropriate to needs and income;

(5) counseling regarding violence, sexual exploitation, substance use, sexually transmitted infections, and pregnancy;

(6) referral for medical services or chemical dependency treatment;

(7) parenting skills;

(8) self-sufficiency support services and independent living skills training;

(9) aftercare and follow-up services; and

(10) services to address the prevention of sexual exploitation and homelessness prevention.

Subd. 6. **Funding.** Funds appropriated for this section may be expended on programs described under subdivisions 3 to 5, technical assistance, and capacity building to meet the greatest need on a statewide basis.

Sec. 6. Laws 2021, First Special Session chapter 7, article 17, section 5, subdivision 1, is amended to read:

Subdivision 1. **Housing transition cost.** (a) This act includes $682,000 in fiscal year 2022 and $1,637,000 in fiscal year 2023 for a onetime payment per transition of up to $3,000 to cover costs associated with moving to a community setting that are not covered by other sources. Covered costs include: (1) lease or rent deposits; (2) security deposits; (3) utilities setup costs, including telephone and Internet services; and (4) essential furnishings and supplies. The commissioner of human services shall seek an amendment to the medical assistance state plan to allow for these payments as a housing stabilization service under Minnesota Statutes, section 256B.051. The general fund base in this act for this purpose is $1,227,000 in fiscal year 2024 and $0 in fiscal year 2025.

~~(b) This subdivision expires March 31, 2024.~~

(b) An individual is only eligible for a housing transition cost payment if the individual is moving from an institution or provider-controlled setting into their own home.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 7. **HOUSING STABILIZATION SERVICES INFLATIONARY ADJUSTMENT.**

The commissioner of human services shall seek federal approval to apply biennial inflationary updates to housing stabilization services rates based on the consumer price index. Beginning January 1, 2024, the commissioner must update rates using the most recently available data from the consumer price index.

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

ARTICLE 7
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of out-of-home placement or already in out-of-home placement in family foster settings as defined in chapter 245A and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care. Allowable

activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services under section 245.4901;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program~~. These may be start-up grants~~, including start-up grants; and.

(18) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder including major depression and bipolar disorders and a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

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

Sec. 2. **[245.4904] EMERGING MOOD DISORDER GRANT PROGRAM.**

Subdivision 1. **Creation.** (a) The emerging mood disorder grant program is established in the Department of Human Services to fund:

(1) evidence-informed interventions for youth and young adults who are at risk of developing a mood disorder or are experiencing an emerging mood disorder, including major depression and bipolar disorders; and

(2) a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

(b) Emerging mood disorder services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (18).

Subd. 2. **Activities.** (a) All emerging mood disorder grant program recipients must:

(1) provide intensive treatment and support to adolescents and young adults experiencing or at risk of experiencing an emerging mood disorder. Intensive treatment and support includes medication management, psychoeducation for the individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early symptoms of mood disorders, screening tools, and best practices;

(3) ensure access for individuals to emerging mood disorder services under this section, including ensuring access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may also be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in emerging mood disorder services.

(c) Grant money may be used by the grantee to evaluate the efficacy of providing intensive services and supports to people with emerging mood disorders.

Subd. 3. **Eligibility.** Program activities must be provided to youth and young adults with early signs of an emerging mood disorder.

Subd. 4. **Outcomes.** Evaluation of program activities must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether individuals experience a reduction in mood disorder symptoms; and

(2) whether individuals experience a decrease in inpatient mental health hospitalizations.

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

Sec. 3. Minnesota Statutes 2022, section 254B.02, subdivision 5, is amended to read:

Subd. 5. ~~**Administrative adjustment**~~ **Local agency allocation.** The commissioner may make payments to local agencies from money allocated under this section to support ~~administrative activities under sections 254B.03 and 254B.04~~ individuals with substance use disorders. The ~~administrative~~ payment must not ~~exceed the lesser of: (1) five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the special revenue account according to subdivision 1; or (2)~~ be less than 133 percent of the local agency ~~administrative~~ payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

Sec. 4. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible

vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5).

(d) A recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

(e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

(f) Hospitals, federally qualified health centers and rural health clinics are eligible vendors of a comprehensive assessment when completed according to section 245G.05 and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

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

Sec. 5. Minnesota Statutes 2022, section 256B.0638, subdivision 1, is amended to read:

Subdivision 1. **Program established.** The commissioner of human services, in conjunction with the commissioner of health, shall coordinate and implement an opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers and to support patient-centered, compassionate care for Minnesotans who require treatment with opioid analgesics.

Sec. 6. Minnesota Statutes 2022, section 256B.0638, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

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

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Minnesota health care program" means a public health care program administered by the commissioner of human services under this chapter and chapter 256L, and the Minnesota restricted recipient program.

(f) "Opioid ~~disenrollment~~ sanction standards" means ~~parameters~~ clinical indicators defined by the Opioid Prescribing Work Group of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider ~~must be disenrolled~~ may be subject to sanctions under section 256B.064 as a ~~medical assistance~~ Minnesota health care program provider.

(g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to ~~medical assistance~~ Minnesota health care program and MinnesotaCare enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(h) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(i) "Program" means the statewide opioid prescribing improvement program established under this section.

(j) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(k) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Sec. 7. Minnesota Statutes 2022, section 256B.0638, subdivision 4, is amended to read:

Subd. 4. **Program components.** (a) The working group shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, including, but not limited to, the following:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which for purposes of this program means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing opioid quality improvement standard thresholds and opioid ~~disenrollment~~ standards for opioid prescribers and provider groups~~. In developing opioid disenrollment standards, the standards may be described in terms of the length of time in which prescribing practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards~~; and

(5) addressing other program issues as determined by the commissioners.

(b) The opioid prescribing protocols shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care or palliative care, or to opioids prescribed for substance use disorder treatment with medications for opioid use disorder.

(c) All opioid prescribers who prescribe opioids to Minnesota health care program enrollees must participate in the program in accordance with subdivision 5. Any other prescriber who prescribes opioids may comply with the components of this program described in paragraph (a) on a voluntary basis.

Sec. 8. Minnesota Statutes 2022, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the ~~programs within the Minnesota health care~~ quality improvement program to improve the health of and quality of care provided to Minnesota health care program enrollees. The program must

be designed to support patient-centered care consistent with community standards of care. The program must discourage unsafe tapering practices and patient abandonment by providers. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) ~~appropriate use of the prescription monitoring program under section 152.126~~ demonstration of patient-centered care consistent with community standards of care.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices for treatment of acute or postacute pain do not improve so that they are consistent with community standards, the commissioner ~~shall~~ may take one or more of the following steps:

(1) require the prescriber, the provider group, or both, to monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts~~, including but not limited to mandatory use of the prescription monitoring program established under section 152.126~~.

(d) Prescribers treating patients who are on chronic, high doses of opioids must meet community standards of care, including performing regular assessments and addressing

unwarranted risks of opioid prescribing, but are not required to show measurable changes in chronic pain prescribing thresholds within a certain period.

(e) The commissioner shall dismiss a prescriber from participating in the opioid prescribing quality improvement program when the prescriber demonstrates that the prescriber's practices are patient-centered and reflect community standards for safe and compassionate treatment of patients experiencing pain.

~~(d)~~ (f) The commissioner ~~shall terminate from Minnesota health care programs~~ may investigate for possible sanctions under section 256B.064 all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid ~~disenrollment~~ sanction standards.

(e) No physician, advanced practice registered nurse, or physician assistant, acting in good faith based on the needs of the patient, may be disenrolled by the commissioner of human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations specified in state or federal opioid prescribing guidelines or policies, or quality improvement thresholds established under this section.

Sec. 9. Minnesota Statutes 2022, section 256B.0638, is amended by adding a subdivision to read:

Subd. 8. **Sanction standards.** (a) Providers enrolled in medical assistance under section 256B.04, subdivision 21, providing services to persons enrolled in medical assistance or MinnesotaCare may be subject to sanctions under section 256B.064 for the following practices:

(1) discontinuing, either abruptly or in the form of a rapid taper, chronic opioid analgesic therapy from daily doses greater or equal to 50 morphine milligram equivalents a day without providing patient support. Discontinuing without providing patient support includes failing to:

(i) document and communicate to the patient a clinical rationale for the opioid discontinuation and for the taper plan or speed;

(ii) ascertain pregnancy status in women of childbearing age prior to beginning the discontinuation;

(iii) provide adequate follow-up care to the patient during the opioid discontinuation;

(iv) document a safety and pain management plan prior to or during the discontinuation;

(v) respond promptly and appropriately to patient-expressed psychological distress, including but not limited to suicidal ideation;

(vi) assess the patient for active, moderate to severe substance use disorder, including but not limited to opioid use disorder, and refer or treat the patient as appropriate; or

(vii) document and address patient harm when it arises. This includes but is not limited to known harms reported by the patient, harms evident in a clinical evaluation, or harms that should have been known through adequate chart review;

(2) continuing chronic opioid analgesic therapy without a safety plan when specific red flags for opioid use disorder are present. Failure to develop a safety plan includes but is not limited to failing to:

(i) document and address risks related to the condition or patterns of behavior and the potential health consequences that an undiagnosed or untreated opioid use disorder poses to the patient;

(ii) pursue a diagnosis when an opioid use disorder is suspected;

(iii) include a clear explanation of the safety plan in the patient's health record and evidence that the plan was communicated to the patient; and

(iv) document the clinical rationale for continuing therapy despite the presence of red flags. Red flags for opioid use disorder that require provider response under this section include:

(A) a history of overdose known to the prescriber or evident from the patient's medical record in the past 12 months;

(B) a history of an episode of opioid withdrawal that is not otherwise explained and is known to the prescriber or evident from the patient's medical record in the past 12 months;

(C) a known history of opioid use disorder. If the opioid use disorder is moderate to severe and the diagnosis was made within the past 12 months, a higher degree of consideration must be included in the safety plan;

(D) a history of opioid use resulting in neglect of other aspects of the patient's health that may result in serious harm known to the prescriber or evident from the patient's medical record in the past 12 months;

(E) an active alcohol use disorder. If the alcohol use disorder is moderate to severe, a higher degree of consideration must be included in the safety plan;

(F) a close personal contact of the patient expressing credible concern about the practice of use or safety of the patient indicating imminent harm to the patient or an opioid use disorder diagnosis;

(G) a pattern of deceptive actions by the patient to obtain opioid prescriptions. Deceptive actions may include but are not limited to forging prescriptions, tampering with prescriptions, and falsely reporting to medical staff with the intent of obtaining or protecting an opioid supply;

(H) a pattern of behavior by the patient that is indicative of loss of control or continued opioid use despite harm. Behaviors indicating a loss of control or continued use include but are not limited to a pattern of recurrent lost prescriptions, patient requests to increase dosage that are not supported by clinical reasoning, and a pattern of early refill requests without a change in clinical condition;

(3) prescribing greater than 400 morphine milligram equivalents per day without assessment of the risk for opioid-induced respiratory depression, without responding to evidence of opioid-related harm, and without mitigating the risk of opioid-induced respiratory depression. Failure to address risk of opioid-related harm includes but is not limited to failure to:

(i) assess and document the diagnosis or diagnoses to be managed with chronic opioid analgesic therapy;

(ii) assess and document comorbid health conditions that may impact the safety of opioid therapy;

(iii) screen and document a patient-specific, opioid-related risk benefit analysis;

(iv) respond to evidence of harm within the patient's medical record. Evidence of harm includes but is not limited to opioid-related falls, nonfatal overdoses, and appearing sedated or with respiratory compromise at clinical visits;

(v) document clinical decision making if dosage is increased;

(vi) document discussion of an opioid taper with the patient on at least an annual basis; and

(vii) evaluate the patient in person at least every three months or failing to assess for diversion;

(4) continuing chronic opioid analgesic therapy at the same dosage without a safety plan when risk factors for serious opioid-induced respiratory depression are present. Failing to

develop a safety plan includes failing to document the risk factor as a risk of opioid-induced respiratory depression in the patient's health record and failing to document a clear safety plan in the patient's health record that addresses actions to reduce the risk for serious opioid-induced respiratory depression. Risk factors for serious opioid-induced respiratory depression include but are not limited to:

(i) an active or symptomatic and untreated substance use disorder;

(ii) a serious mental health condition, including symptomatic, untreated mania; symptomatic, untreated psychosis; and symptomatic, untreated suicidality;

(iii) an emergency department visit with a life-threatening opioid complication in the last 12 months;

(iv) a pattern of inconsistent urine toxicology results, excluding the presence of cannabinoids; however, addressing an inconsistent urine toxicology result must not result in the overall worsening clinical status of the patient;

(v) the concurrent prescribing of long-term benzodiazepine therapy to an individual on chronic opioid analgesic therapy;

(vi) a pulmonary disease with respiratory failure or hypoventilation; and

(vii) a failure to select and dose opioids safely for patients with known renal insufficiency; and

(5) failing to participate in the Opioid Prescribing Improvement program for two consecutive years.

Sec. 10. Minnesota Statutes 2022, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine

was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

(c) The commissioner may impose sanctions against a vendor for violations of the sanction standards defined by the Opioid Prescribing Work Group for opioid prescribing practices that fall outside community standard thresholds for prescribing.

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

Sec. 11. Minnesota Statutes 2022, section 256B.0941, is amended by adding a subdivision to read:

Subd. 5. **Start-up and capacity-building grants.** (a) Start-up grants to prospective psychiatric residential treatment facility sites may be used for:

(1) administrative expenses;

(2) consulting services;

(3) Health Insurance Portability and Accountability Act of 1996 compliance;

(4) therapeutic resources including evidence-based, culturally appropriate curriculums and training programs for staff and clients;

(5) allowable physical renovations to the property; and

(6) emergency workforce shortage uses, as determined by the commissioner.

(b) Start-up and capacity-building grants to prospective and current psychiatric residential treatment facilities may be used to support providers who treat and accept individuals with complex support needs, including but not limited to:

(1) neurocognitive disorders;

(2) co-occurring intellectual developmental disabilities;

(3) schizophrenia spectrum disorders;

(4) manifested or labeled aggressive behaviors; and

(5) manifested sexually inappropriate behaviors.

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

Sec. 12. **MOBILE RESPONSE AND STABILIZATION SERVICES PILOT.**

The commissioner shall establish a pilot to promote access to crisis response services and reduce psychiatric hospitalizations and out-of-home placement services for children, youth, and families. The pilot will incorporate a two-pronged approach to provide an immediate, in-person response within 60 minutes of crisis as well as extended, longer-term supports for the family unit. The pilot must aim to help families respond to children's behavioral health crisis while bolstering resiliency and recovery within the family unit. The commissioner must consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

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

Sec. 13. **LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION.**

The commissioner of human services shall evaluate the ongoing need for local agency substance use disorder allocations under section 254B.02. The evaluation must include recommendations on whether local agency allocations should continue, and if so, the evaluation must recommend what the purpose of the allocations should be and propose an updated allocation methodology that aligns with the purpose and person-centered outcomes for people experiencing substance use disorders and behavioral health conditions. The commissioner may contract with a vendor to support this evaluation through research and actuarial analysis.

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

ARTICLE 8
HEALTH CARE

Section 1. Minnesota Statutes 2022, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements ~~of~~ for health insurers under the federal Deficit Reduction Act of 2005, Public Law 109-171 and the federal Consolidated Appropriations Act of 2022, Public Law 117-103, including any federal regulations adopted under ~~that act~~ those acts, to the extent that ~~it imposes~~ they impose a requirement that applies in this state and that is not also required by the laws of

this state. This section does not require compliance with any provision of the federal ~~act~~ acts prior to the effective ~~date~~ dates provided for ~~that provision~~ those provisions in the federal ~~act~~ acts. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B; or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials

issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a clean claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. A health insurer must process all other claims made by a state agency for covered expenses paid under a state medical program within the timeline set forth in Code of Federal Regulations, title 42, section 447.45(d)(4).

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

Sec. 2. Minnesota Statutes 2022, section 62A.673, subdivision 2, is amended to read:

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

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, ~~2023~~ 2025, telehealth also includes audio-only communication between a health care provider and a patient in accordance with subdivision 6, paragraph (b). Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

Sec. 3. Minnesota Statutes 2022, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under chapter 119B, the MFIP program formerly codified under sections 256.031 to 256.0361, and the AFDC program formerly codified under sections 256.72 to 256.871; section 256.045, subdivision 10; chapters 256B for state-funded medical assistance, 256D, 256I, 256J, 256K,

and 256L for state-funded MinnesotaCare; and the Supplemental Nutrition Assistance Program (SNAP), except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

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

Sec. 4. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total

aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available, except that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness.

Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

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

Sec. 5. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed

children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received medical assistance payment for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that is a level one trauma center and that has a medical assistance utilization rate in the base year that is at least two and ~~one-half~~ one-quarter standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

(f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to

enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed $1,500,000.

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

Sec. 6. Minnesota Statutes 2022, section 256.969, subdivision 25, is amended to read:

Subd. 25. **Long-term hospital rates.** (a) Long-term hospitals shall be paid on a per diem basis.

(b) For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

(c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid the higher of a per diem amount computed using the methodology described in subdivision 2b, paragraph (i), or the per diem rate as of July 1, 2021.

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

Sec. 7. Minnesota Statutes 2022, section 256B.055, subdivision 17, is amended to read:

Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age, and who was enrolled in medical assistance under the state plan or a waiver of the plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

(b) Beginning July 1, 2023, medical assistance may be paid for a person under 26 years of age who was in foster care on the date of attaining 18 years of age and enrolled in another state's Medicaid program while in foster care in accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018. Public Law 115-271, section 1002.

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

Sec. 8. Minnesota Statutes 2022, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(b) Notwithstanding any other law to the contrary:

(1) a child under 21 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months; and

(2) a child under six years of age who is determined eligible for medical assistance must remain eligible through the month in which the child reaches six years of age.

(c) A child's eligibility under paragraph (b) may be terminated earlier if:

(1) the child attains the maximum age;

(2) the child or the child's representative requests voluntary termination of eligibility;

(3) the child ceases to be a resident of the state;

(4) the child dies; or

(5) the agency determines eligibility was erroneously granted at the most recent eligibility determination due to agency error or fraud, abuse, or perjury attributed to the child or the child's representative.

~~(b)~~ (d) For a person eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the person eligible for medical assistance, eligibility is available for the month the change was reported and for three months prior to the month the change was reported, if the person was eligible in those prior months.

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

Sec. 9. Minnesota Statutes 2022, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers medically necessary dental services.

~~(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:~~

~~(1) comprehensive exams, limited to once every five years;~~

~~(2) periodic exams, limited to one per year;~~

~~(3) limited exams;~~

~~(4) bitewing x-rays, limited to one per year;~~

~~(5) periapical x-rays;~~

~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;~~

~~(7) prophylaxis, limited to one per year;~~

~~(8) application of fluoride varnish, limited to one per year;~~

~~(9) posterior fillings, all at the amalgam rate;~~

~~(10) anterior fillings;~~

~~(11) endodontics, limited to root canals on the anterior and premolars only;~~

~~(12) removable prostheses, each dental arch limited to one every six years;~~

~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~

~~(14) palliative treatment and sedative fillings for relief of pain;~~

~~(15) full-mouth debridement, limited to one every five years; and~~

~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.~~

~~(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:~~

~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~

~~(2) general anesthesia; and~~

~~(3) full-mouth survey once every five years.~~

~~(d) Medical assistance covers medically necessary dental services for children and pregnant women.~~ (b) The following guidelines apply to dental services:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

~~(e)~~ (c) In addition to the services specified in ~~paragraphs~~ paragraph (b) ~~and (c)~~, medical assistance covers the following services ~~for adults~~:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

~~(f)~~ (d) The commissioner shall not require prior authorization for the services included in paragraph ~~(e)~~ (c), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph ~~(e)~~ (c), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

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

Sec. 10. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of at least four licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and ~~one~~ two consumer ~~representative~~ representatives, one of which is a current or former medical assistance enrollee or the parent or guardian of a current or former medical assistance enrollee; the remainder

to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. Notwithstanding section 15.059, subdivision 6, the Formulary Committee ~~expires June 30, 2023~~ does not expire.

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

Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $10.77 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65

for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f,

paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section 256.01, subdivision 42, this paragraph does not expire.

(i) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

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

Sec. 12. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13k. **Value-based purchasing arrangements.** (a) The commissioner may enter into a value-based purchasing arrangement for the medical assistance or MinnesotaCare program by written arrangement with a drug manufacturer based on agreed-upon metrics. The commissioner may enter into a contract with a vendor for the purpose of participating in a value-based purchasing arrangement. A value-based purchasing arrangement may include a rebate, a discount, a price reduction, risk sharing, a reimbursement, a guarantee, shared savings payments, withholds, a bonus, or any other thing of value. A value-based purchasing arrangement must provide the same amount or more of a value or discount in

the aggregate as would claiming the mandatory federal drug rebate under the Federal Social Security Act, section 1927.

(b) Nothing in this section shall be interpreted as requiring a drug manufacturer or the commissioner to enter into an arrangement as described in paragraph (a).

(c) Nothing in this section shall be interpreted as altering or modifying medical assistance coverage requirements under the federal Social Security Act, section 1927.

(d) If the commissioner determines that a state plan amendment is necessary for implementation before implementing a value-based purchasing arrangement, the commissioner shall request the amendment and may delay implementing this provision until the amendment is approved.

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

Sec. 13. Minnesota Statutes 2022, section 256B.0625, subdivision 28b, is amended to read:

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum. The commissioner shall enroll doula agencies and individual treating doulas to provide direct reimbursement.

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

Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit

an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the

commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior

to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

Sec. 15. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided ~~on or after~~ from September 1, 2011, to December 31, 2023:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive

co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

(f) For services provided on or after January 1, 2024, the medical assistance benefit plan must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

Sec. 16. Minnesota Statutes 2022, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians

and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $6,000,000 per year. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for

Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities. The commissioner shall not make payments to governmental entities eligible to receive payments described

in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within 24 months of the initial request from the commissioner.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

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

Sec. 17. Minnesota Statutes 2022, 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; and

(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.

~~(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.~~

~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner~~

~~returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~

~~The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.~~

~~(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.~~

~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~

~~The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.~~

~~(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.~~

~~The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~

~~The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.~~

~~(h)~~ (e) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 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. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(i)~~ (f) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three 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. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(j)~~ (g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

~~(k)~~ (h) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

~~(l)~~ (i) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

~~(m)~~ (j) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

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

Sec. 18. Minnesota Statutes 2022, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases

except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech

pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(i) The commissioner may reimburse the cost incurred to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients when the sample is collected outside of an inpatient hospital setting or freestanding birth center setting because the newborn was born outside of a hospital setting or freestanding birth center setting or because it is not medically appropriate to collect the sample during the inpatient stay for the birth.

(j) Effective for service rendered on or after January 1, 2024, payment rates for family planning and abortion services shall be increased by ten percent. This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

Sec. 19. Minnesota Statutes 2022, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered ~~on or after~~ from October 1, 1992, to December 31, 2023, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) ~~Beginning~~ From October 1, 1999, to December 31, 2023, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered ~~on or after~~ from January 1, 2000, to December 31, 2023, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided ~~on or after~~ from January 1, 2002, to December 31, 2023, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

~~(h) Effective for services rendered on or after January 1, 2014, through December 31, 2021, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.~~

~~(i) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care~~

~~plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.~~

~~(j) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.~~

~~(k)~~ (h) Effective for services provided on or after January 1, 2022, the commissioner shall exclude from medical assistance and MinnesotaCare payments for dental services to public health and community health clinics the 20 percent increase authorized under Laws 1989, chapter 327, section 5, subdivision 2, paragraph (b).

~~(l)~~ (i) Effective for services provided ~~on or after~~ from January 1, 2022, to December 31, 2023, the commissioner shall increase payment rates by 98 percent for all dental services. This rate increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, or Indian health services.

~~(m)~~ (j) Managed care plans and county-based purchasing plans shall reimburse providers at a level that is at least equal to the rate paid under fee-for-service for dental services. If, for any coverage year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

(k) Effective for services provided on or after January 1, 2024, payment for dental services must be the lower of submitted charges or the percentile of 2018-submitted charges from claims paid by the commissioner so that the total aggregate expenditures does not exceed the total spend as outlined in the applicable paragraphs (a) to (k). This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

(l) Beginning January 1, 2027, and every three years thereafter, the commissioner shall rebase payment rates for dental services to a percentile of submitted charges for the applicable base year using charge data from claims paid by the commissioner so that the total aggregate expenditures does not exceed the total spend as outlined in paragraph (k) plus the change in the Medical Economic Index (MEI). In 2027, the change in the MEI must be measured from midyear of 2024 and 2026. For each subsequent rebasing, the change in the MEI must be measured between the years that are one year after the rebasing years. The base year used for each rebasing must be the calendar year that is two years prior to the effective date of the rebasing. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

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

Sec. 20. Minnesota Statutes 2022, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** ~~(a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.~~

~~(b) For dental services rendered on or after July 1, 2016, through December 31, 2021, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (f), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.~~

~~(c)~~ (a) The commissioner shall increase reimbursement to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services provided on or after January 1, 2022, by a dental provider deemed to be a critical access dental provider under paragraph (f), the commissioner shall increase reimbursement by 20 percent above the reimbursement rate that would otherwise be paid to the critical access

dental provider. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

~~(d)~~ (b) Managed care plans and county-based purchasing plans shall increase reimbursement to critical access dental providers by at least the amount specified in paragraph (c). If, for any coverage year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

~~(e)~~ (c) Critical access dental payments made under this subdivision for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

~~(f)~~ (d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

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

Sec. 21. Minnesota Statutes 2022, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the exception of children under 19 years of age, are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

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

Sec. 22. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended by Laws 2021, First Special Session chapter 7, article 2, section 71, and Laws 2022, chapter 98, article 4, section 49, is amended to read:

Subdivision 1. **Waivers and modifications; federal funding extension.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following waivers and modifications to human services programs issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12 may remain in effect for the time period set out in applicable federal law or for the time period set out in any applicable federally approved waiver or state plan amendment, whichever is later:

(1) CV15: allowing telephone or video visits for waiver programs;

(2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare as needed to comply with federal guidance from the Centers for Medicare and Medicaid Services until an enrollee's first renewal following the resumption of medical assistance and MinnesotaCare renewals after March 31, 2023;

(3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

(5) CV24: allowing telephone or video use for targeted case management visits;

(6) CV30: expanding telemedicine in health care, mental health, and substance use disorder settings;

(7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(10) CV43: expanding remote home and community-based waiver services;

(11) CV44: allowing remote delivery of adult day services;

(12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance Program;

(13) CV60: modifying eligibility period for the federally funded Refugee Social Services Program; and

(14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and Minnesota Family Investment Program maximum food benefits.

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

Sec. 23. Laws 2021, First Special Session chapter 7, article 1, section 36, is amended to read:

Sec. 36. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

(a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06, subdivision 3, or any other provision to the contrary, the commissioner shall not collect any unpaid premium for a coverage month ~~that occurred during the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services~~ until after an enrollee's first renewal following the resumption of medical assistance and MinnesotaCare renewals after March 31, 2023.

(b) Notwithstanding any provision to the contrary, periodic data matching under Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to ~~six~~ 12 months following the ~~last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services~~ resumption of medical assistance and MinnesotaCare renewals after March 31, 2023.

(c) Notwithstanding any provision to the contrary, the requirement for the commissioner of human services to issue an annual report on periodic data matching under Minnesota Statutes, section 256B.0561, is suspended for one year following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(d) For an individual enrolled in medical assistance as of March 31, 2023, assets exceeding the limits established by Minnesota Statutes, section 256B.056, subdivision 3,

paragraph (a), must be disregarded until the individual's second annual renewal after the resumption of renewals after March 31, 2023.

(e) The commissioner may temporarily adjust medical assistance eligibility verification requirements as needed to comply with federal guidance and ensure a timely renewal process for the period during which enrollees are subject to their first annual renewal after March 31, 2023. The commissioner shall implement sufficient controls to monitor the effectiveness of verification adjustments and ensure program integrity.

(f) Notwithstanding any law to the contrary, the commissioner may temporarily extend the time frame permitted to take final administrative action on fair hearing requests from medical assistance recipients under Minnesota Statutes, section 256.045, until the end of the 23rd month after the public health emergency for COVID-19, as declared by the United States Secretary of Health and Human Services, ends. During this period, the commissioner must:

(1) not delay resolving expedited fair hearings described in Code of Federal Regulations, title 42, chapter IV, subchapter C, part 431, subpart E, section 431.224, paragraph (a);

(2) provide medical assistance benefits pending the outcome of a fair hearing decision to any medical assistance recipient who requests a fair hearing within the time provided under Minnesota Statutes, section 256.045, subdivision 3, paragraph (i), regardless of whether the recipient has requested benefits pending the outcome of the fair hearing;

(3) reinstate medical assistance benefits retroactively to the date of agency action if the recipient requests a fair hearing after the date of agency action and within the time provided under Minnesota Statutes, section 256.045, subdivision 3, paragraph (i);

(4) take final administrative action within the maximum 90 days permitted under Code of Federal Regulations, title 42, chapter IV, subchapter C, part 431, subpart E, section 431.244, paragraph (f)(1), for fair hearing requests where medical assistance benefits cannot be provided pending the outcome of the fair hearing, such as a fair hearing challenging a denial of eligibility for an applicant;

(5) not recoup or recover from the recipient the cost of medical assistance benefits provided pending final administrative action, even if the agency action is sustained by the hearing decision; and

(6) not use the authority under this paragraph as justification to delay taking final agency action and only exceed the 90 days permitted for taking final agency action under Code of Federal Regulations, title 42, chapter IV, subchapter C, part 431, subpart E, section 431.244,

paragraph (f)(1), to the extent the commissioner is unable to take timely final agency action on a given fair hearing request.

EFFECTIVE DATE. This section is effective the day following final enactment, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to read:

Sec. 26. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19 HUMAN SERVICES PROGRAM MODIFICATIONS.**

Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following modifications issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect until July 1, ~~2023~~ 2025:

(1) CV16: expanding access to telemedicine services for Children's Health Insurance Program, Medical Assistance, and MinnesotaCare enrollees; and

(2) CV21: allowing telemedicine alternative for school-linked mental health services and intermediate school district mental health services.

ARTICLE 9
MEDICAL EDUCATION AND RESEARCH COST ACCOUNT

Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply:

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

(c) "Commissioner" means the commissioner of health.

(d) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy students and residents), doctors of chiropractic, dentists (dental students and residents), advanced practice registered nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(g) "Trainee" means a student or resident involved in a clinical medical education program.

(h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs in either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues. Training that occurs in nursing facility settings is not eligible for funding under this section.

Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program ~~and must be received by October 31 of each year for distribution in the following year~~ on a timeline determined by the commissioner. An application for funds must contain ~~the following information:~~ information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;~~

~~(2) the name, title, and business address of those persons responsible for administering the funds;~~

~~(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and~~

~~(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.~~

~~(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:~~

~~(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;~~

~~(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and~~

~~(3) other revenue received for the purposes of clinical training.~~

~~(c)~~ (d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the ~~current~~ applicable funding cycle.

Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute ~~the available medical education funds~~ revenue credited or money transferred to the medical education and research cost account under subdivision 8 and section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. ~~For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.~~

Training sites whose training site level grant is less than $5,000, based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision.

(b) ~~For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The~~

~~supplemental public program volume factor shall be equal to ten percent of each training site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).~~ Money appropriated through the state general fund, the health care access fund, and any additional fund for the purpose of funding medical education and research costs and that does not require federal approval must be awarded only to eligible training sites who do not qualify for a medical education and research cost rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph (b). The commissioner shall distribute the available medical education money appropriated to eligible training sites that do not qualify for a medical education and research cost rate factor based on a distribution formula determined by the commissioner. The distribution formula under this paragraph must consider clinical training costs, public program revenues, and other factors identified by the commissioner that address the objective of supporting clinical training.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include ~~the withholding of payments~~ disqualifying the training site under this section or the removal of students from the site.

(e) Use of funds is limited to expenses related to eligible clinical training ~~program~~ costs ~~for eligible programs~~. The commissioner shall develop a methodology for determining eligible costs.

(f) Any funds ~~not~~ that cannot be distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. ~~The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~ When appropriate, the commissioner shall include the undistributed money in the subsequent distribution cycle using the applicable methodology described in this subdivision.

~~(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.~~

Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must ~~sign and~~ submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. ~~If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

(b) The reports must provide verification of the distribution of the funds and must include:

~~(1) the total number of eligible trainee FTEs in each clinical medical education program;~~

~~(2) the name of each funded program and, for each program, the dollar amount distributed to each training site and a training site expenditure report;~~

~~(3)~~ (1) documentation of any discrepancies between the ~~initial~~ grant distribution notice included in the commissioner's approval letter and the actual distribution;

~~(4)~~ (2) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

~~(5)~~ (3) other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

~~(c) Each year, the commissioner shall provide an annual summary report to the legislature on the implementation of this section. This report is exempt from section 144.05, subdivision 7.~~

Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek ~~to maximize~~ federal financial participation ~~in payments~~ for the dedicated revenue for medical education and research costs provided under section 297F.10, subdivision 1, clause (2).

~~The commissioner shall use physician clinic rates where possible to maximize federal financial participation. Any additional funds that become available must be distributed under subdivision 4, paragraph (a).~~

Sec. 6. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled

rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

(k) Effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692 subdivision 4, paragraph (a).

(l) By [month] [date], [year], the commissioner shall make a one-time supplemental payment to each hospital that qualifies for a medical education and research cost distribution under section 62J.692, subdivision 4, paragraph (a), in an amount sufficient to cover the six-month funding gap created by the effective date of paragraph (k) in the last six months of calendar year 2023.

Sec. 7. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current

statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 8. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes, as well as related penalties, interest, license fees, and miscellaneous sources of revenue shall be deposited by the commissioner in the state treasury and credited as follows:

(1) $22,250,000 each year must be credited to the Academic Health Center special revenue fund hereby created and is annually appropriated to the Board of Regents at the University of Minnesota for Academic Health Center funding at the University of Minnesota; and

(2) ~~$3,937,000~~ $3,788,000 each year must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph (a); and

(3) the balance of the revenues derived from taxes, penalties, and interest (under this chapter) and from license fees and miscellaneous sources of revenue shall be credited to the general fund.

Sec. 9. **REPEALER.**

Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision 1; and 256B.69, subdivision 5c, are repealed.

ARTICLE 10
MINNESOTACARE PUBLIC OPTION

Section 1. Minnesota Statutes 2022, section 256L.04, subdivision 1c, is amended to read:

Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare with an income less than or equal to 200 percent of the federal poverty guidelines shall not be

considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 2. Minnesota Statutes 2022, section 256L.04, subdivision 7a, is amended to read:

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program, except as provided in subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2022, section 256L.04, is amended by adding a subdivision to read:

Subd. 15. **Persons eligible for buy-in option.** (a) Families and individuals with income above the maximum income eligibility limit specified in subdivision 1 or 7, including those with access to employer-sponsored coverage as defined by section 256L.07, subdivision 2, but who meet all other MinnesotaCare eligibility requirements are eligible for the buy-in option. All other provisions of this chapter apply unless otherwise specified.

(b) Families and individuals may enroll in MinnesotaCare under this subdivision only during an annual open enrollment period or special enrollment period, as designated by MNsure and in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2022, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty

guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner, unless they continue MinnesotaCare enrollment through the buy-in option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2022, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d), subject to the federal compliance requirements in paragraphs (e) and (f).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	**Less than**	**Individual Premium Amount**
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14

120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$37
160%	170%	$44
170%	180%	$52
180%	190%	$61
190%	200%	$71
200%		$80

(e) Beginning January 1, 2021, the commissioner shall adjust the premium scale established under paragraph (d) to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505 (a)(1).

(f) Notwithstanding the premium scale established under paragraph (d), the commissioner shall continue to charge premiums in accordance with the simplified premium scale established to comply with the American Rescue Plan Act of 2021, as amended by the Inflation Reduction Act of 2022, and in effect from January 1, 2021, to December 31, 2025, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The commissioner shall further adjust the premium scale established under paragraph (d) to ensure compliance with paragraph (e) as needed in response to changes in federal law.

(g) The commissioner shall establish a sliding premium scale for persons eligible through the buy-in option under section 256L.04, subdivision 15. Beginning January 1, 2027, persons eligible through the buy-in option shall pay premiums according to the premium scale established by the commissioner. Persons 20 years of age or younger are exempt from paying premiums.

EFFECTIVE DATE. This section is effective the day following final enactment, except that the premium scale established under paragraph (g) is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. **TRANSITION TO MINNESOTACARE BUY-IN OPTION.**

(a) The commissioner of human services shall continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5.

(b) By January 1, 2027, the commissioner of human services shall implement a buy-in option that allows individuals with income over 200 percent of the federal poverty guidelines to be eligible for MinnesotaCare.

(c) By December 15, 2024, the commissioner shall present an implementation plan for the MinnesotaCare buy-in option under Minnesota Statutes, section 256L.04, subdivision 15, as well as any additional legislative changes needed for implementation, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

(d) The commissioner of human services shall seek any federal waivers, approvals, and law changes necessary to implement a MinnesotaCare buy-in option, including but not limited to any waivers, approvals, or law changes necessary to allow:

(1) the state to continue to receive federal basic health program payments for basic health program-eligible MinnesotaCare enrollees and to receive other federal funding for the MinnesotaCare public option; and

(2) the state to receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with household incomes greater than 200 percent of the federal poverty guidelines would have otherwise received.

(e) In implementing this section, the commissioner of human services shall consult with the commissioner of commerce and the board of directors of MNsure and may contract for technical and actuarial assistance.

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

ARTICLE 11
TRIBAL ELDER OFFICE

Section 1. **[256.9747] TRIBAL LONG-TERM SERVICES AND SUPPORTS OFFICE.**

(a) The commissioner of human services shall establish a Tribal Long-Term Services and Supports Office to promote and facilitate the sovereignty of Minnesota's Tribal Nations, and to support the consultation duties of the government-to-government relationship with the state and Tribal governments, as set forth in section 10.65.

(b) The purpose of the Tribal Long-Term Services and Supports Office is to demonstrate respect for the sovereign status of Minnesota's Tribal Nations by:

(1) supporting Tribal Nations by delivering tailored technical assistance to bolster Tribes' ability to deliver long-term services and supports;

(2) maximizing access to federal funds and leveraging other resources available to Tribal Nations, including but not limited to assisting Minnesota Tribal Nations access to Title VI of the Older Americans Act; and

(3) increasing access to culturally appropriate health care for Tribes and members.

Sec. 2. **[256.9748] TRIBAL LONG-TERM SERVICES AND SUPPORTS ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** A Tribal Long-Term Services and Supports Advisory Council is created to assist the state authority on developing policies, procedures, and enhanced programs to support older adults and people with a variety of disabilities, including but not limited to developmental disabilities, chronic medical conditions, acquired or traumatic brain injuries, and physical disabilities.

Subd. 2. **Membership terms, compensation, removal, and expiration.** (a) The council must consist of the following 11 voting members appointed by the commissioner:

(1) an American Indian representing the Red Lake Band of Chippewa Indians;

(2) an American Indian representing the Fond du Lac Band, Minnesota Chippewa Tribe;

(3) an American Indian representing the Grand Portage Band, Minnesota Chippewa Tribe;

(4) an American Indian representing the Leech Lake Band, Minnesota Chippewa Tribe;

(5) an American Indian representing the Mille Lacs Band, Minnesota Chippewa Tribe;

(6) an American Indian representing the Bois Forte Band, Minnesota Chippewa Tribe;

(7) an American Indian representing the White Earth Band, Minnesota Chippewa Tribe;

(8) an American Indian representing the Lower Sioux Indian Reservation;

(9) an American Indian representing the Prairie Island Sioux Indian Reservation;

(10) an American Indian representing the Shakopee Mdewakanton Sioux Indian Reservation; and

(11) an American Indian representing the Upper Sioux Indian Reservation.

(b) The terms, compensation, and removal of Tribal Long-Term Services and Supports Advisory Council members must be as provided in section 15.059.

Sec. 3. Minnesota Statutes 2022, section 256B.0924, subdivision 5, is amended to read:

Subd. 5. **Provider standards.** County boards, Tribal Nations, or providers who contract with the county are eligible to receive medical assistance reimbursement for adult targeted case management services. To qualify as a provider of targeted case management services the vendor must:

(1) have demonstrated the capacity and experience to provide the activities of case management services defined in subdivision 4;

(2) be able to coordinate and link community resources needed by the recipient;

(3) have the administrative capacity and experience to serve the eligible population in providing services and to ensure quality of services under state and federal requirements;

(4) have a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(5) have the capacity to document and maintain individual case records complying with state and federal requirements;

(6) coordinate with county social service agencies responsible for planning for community social services under chapters 256E and 256F; conducting adult protective investigations under section 626.557, and conducting prepetition screenings for commitments under section 253B.07;

(7) coordinate with health care providers to ensure access to necessary health care services;

(8) have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management service provider also provides the recipient's services and supports and provides information on all potential conflicts of interest and obtains the recipient's informed consent and provides the recipient with alternatives; and

(9) have demonstrated the capacity to achieve the following performance outcomes: access, quality, and consumer satisfaction.

ARTICLE 12

BACKGROUND STUDIES

Section 1. Minnesota Statutes 2022, section 245C.10, subdivision 1d, is amended to read:

Subd. 1d. **State; national criminal history record check fees.** The commissioner may increase background study fees as necessary, commensurate with an increase in state Bureau of Criminal Apprehension or the national criminal history record check ~~fee~~ fees. The commissioner shall report any fee increase under this subdivision to the legislature during the legislative session following the fee increase, so that the legislature may consider adoption of the fee increase into statute. By July 1 of every year, background study fees shall be set at the amount adopted by the legislature under this section.

Sec. 2. Minnesota Statutes 2022, section 245C.10, subdivision 2, is amended to read:

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than ~~$42~~ $44 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than ~~$42~~ $44 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 4. Minnesota Statutes 2022, section 245C.10, subdivision 4, is amended to read:

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than ~~$42~~ $44 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 6. Minnesota Statutes 2022, section 245C.10, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than ~~$42~~ $44 per study.

Sec. 7. Minnesota Statutes 2022, section 245C.10, subdivision 8, is amended to read:

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 8. Minnesota Statutes 2022, section 245C.10, subdivision 9, is amended to read:

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the home where child foster care services are provided, family child care, child care centers, certified license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than ~~$42~~ $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 9. Minnesota Statutes 2022, section 245C.10, subdivision 9a, is amended to read:

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than ~~$40~~ $44 per study charged to the license holder. A fee of no more than ~~$42~~ $44 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Sec. 10. Minnesota Statutes 2022, section 245C.10, subdivision 10, is amended to read:

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider providing service functions under section 256B.85, subdivision 13, through a fee of no more than ~~$42~~ $44 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 11. Minnesota Statutes 2022, section 245C.10, subdivision 11, is amended to read:

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 12. Minnesota Statutes 2022, section 245C.10, subdivision 12, is amended to read:

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 260E.36, subdivision 3, through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 13. Minnesota Statutes 2022, section 245C.10, subdivision 13, is amended to read:

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under

section 174.30 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 14. Minnesota Statutes 2022, section 245C.10, subdivision 14, is amended to read:

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 15. Minnesota Statutes 2022, section 245C.10, subdivision 16, is amended to read:

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section 256B.051 through a fee of no more than ~~$42~~ $44 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 16. Minnesota Statutes 2022, section 245C.10, subdivision 17, is amended to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 15, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than ~~$42~~ $44 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 17. Minnesota Statutes 2022, section 245C.10, subdivision 20, is amended to read:

Subd. 20. **Professional Educators Licensing Standards Board.** The commissioner shall recover the cost of background studies initiated by the Professional Educators Licensing Standards Board through a fee of no more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 18. Minnesota Statutes 2022, section 245C.10, subdivision 21, is amended to read:

Subd. 21. **Board of School Administrators.** The commissioner shall recover the cost of background studies initiated by the Board of School Administrators through a fee of no

more than ~~$51~~ $53 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Sec. 19. Minnesota Statutes 2022, section 245C.10, is amended by adding a subdivision to read:

Subd. 22. **Tribal organizations.** The commissioner shall recover the cost of background studies initiated by Tribal organizations under section 245C.34 for adoption and child foster care. The fee amount shall be established through interagency agreements between the commissioner and Tribal organizations or their designees. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks. This change shall go into effect July 1, 2024.

Sec. 20. Minnesota Statutes 2022, section 245C.32, subdivision 2, is amended to read:

Subd. 2. **Use.** (a) The commissioner may also use these systems and records to obtain and provide criminal history data from the Bureau of Criminal Apprehension, criminal history data held by the commissioner, and data about substantiated maltreatment under section 626.557 or chapter 260E, for other purposes, provided that:

(1) the background study is specifically authorized in statute; or

(2) the request is made with the informed consent of the subject of the study as provided in section 13.05, subdivision 4.

(b) An individual making a request under paragraph (a), clause (2), must agree in writing not to disclose the data to any other individual without the consent of the subject of the data.

(c) The commissioner may use these systems to share background study documentation electronically with entities and individuals who are the subject of a background study.

~~(c)~~ (d) The commissioner may recover the cost of obtaining and providing background study data by charging the individual or entity requesting the study a fee ~~of no more than $42 per study~~ as described in section 245C.10. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 21. **[245J.01] TITLE.**

This chapter may be cited as the "Department of Human Services Public Law Background Studies Act."

Sec. 22. **[245J.02] DEFINITIONS.**

Subdivision 1. **Scope.** The definitions in this section apply to this chapter.

Subd. 2. **Access to persons served by a program.** "Access to persons served by a program" means physical access to persons receiving services, access to the persons' personal property, or access to the persons' personal, financial, or health information, without continuous, direct supervision, as defined in subdivision 8.

Subd. 3. **Applicant.** "Applicant" has the meaning given in section 245A.02, subdivision 3, and applies to entities listed in section 245J.03.

Subd. 4. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection vendor" means a qualified organization under a written contract with the commissioner to provide services in accordance with section 245J.05, subdivision 6, paragraph (a).

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 6. **Continuous, direct supervision.** "Continuous, direct supervision" means an individual is within sight or hearing of the entity's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program.

Subd. 7. **Conviction.** "Conviction" has the meaning given in section 609.02, subdivision 5.

Subd. 8. **Direct contact.** "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program.

Subd. 9. **Employee.** "Employee" means an individual who provides or seeks to provide services for an entity with which the employee is affiliated in NETStudy 2.0 and who is subject to oversight by the entity, including but not limited to continuous, direct supervision and immediate removal from providing direct care services.

Subd. 10. **Entity.** "Entity" means a program, organization, or agency listed in section 245J.03.

Subd. 11. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 12. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9, and applies to entities listed in section 245J.03.

Subd. 13. **National criminal history record check.** (a) "National criminal history record check" means a check of records maintained by the Federal Bureau of Investigation through

submission of fingerprints through the Bureau of Criminal Apprehension to the Federal Bureau of Investigation, when specifically required by law.

(b) For the purposes of this chapter, "national crime information database," "national criminal records repository," "criminal history with the Federal Bureau of Investigation," and "national criminal record check" refer to a national criminal history record check as defined in this subdivision.

Subd. 14. **NETStudy 2.0.** "NETStudy 2.0" means the commissioner's system that replaces both NETStudy and the department's internal background study processing system. NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by improving the accuracy of background studies through fingerprint-based criminal record checks and expanding the background studies to include a review of information from the Minnesota Court Information System and the national crime information database. NETStudy 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

(1) providing access to and updates from public web-based data related to employment eligibility;

(2) decreasing the need for repeat studies through electronic updates of background study subjects' criminal records;

(3) supporting identity verification using subjects' Social Security numbers and photographs;

(4) using electronic employer notifications; and

(5) issuing immediate verification of subjects' eligibility to provide services as more studies are completed under the NETStudy 2.0 system.

Subd. 15. **Person.** "Person" means a child as defined in subdivision 6 or an adult as defined in section 245A.02, subdivision 2.

Subd. 16. **Public law background study.** "Public law background study" means a background study conducted by the Department of Human Services under this chapter. All data obtained by the commissioner for a background study completed under this chapter shall be classified as private data.

Subd. 17. **Reasonable cause.** "Reasonable cause" means information or circumstances exist that provide the commissioner with articulable suspicion that further pertinent information may exist concerning a subject. The commissioner has reasonable cause to require a background study when the commissioner has received a report from the subject,

the entity, or a third party indicating that the subject has a history that would disqualify the individual or that may pose a risk to the health or safety of persons receiving services.

Subd. 18. **Reasonable cause to require a national criminal history record check.** (a) "Reasonable cause to require a national criminal history record check" means information or circumstances exist that provide the commissioner with articulable suspicion that further pertinent information may exist concerning a background study subject that merits conducting a national criminal history record check on that subject. The commissioner has reasonable cause to require a national criminal history record check when:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota; or

(4) information from the Bureau of Criminal Apprehension for a state-based name and date of birth background study in which the subject is a minor that indicates that the subject has a criminal history.

(b) In addition to the circumstances described in paragraph (a), the commissioner has reasonable cause to require a national criminal history record check if the subject is not currently residing in Minnesota or resided in a jurisdiction other than Minnesota during the previous five years.

Subd. 19. **Recurring maltreatment.** "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred and that the subject was responsible for the maltreatment.

Subd. 20. **Results.** "Results" means a determination that a study subject is eligible, disqualified, set aside, granted a variance, or that more time is needed to complete the background study.

Subd. 21. **Roster.** (a) "Roster" means the electronic method used to identify the entity or entities required to conduct background studies under this chapter with which a background subject is affiliated. There are three types of rosters: active roster, inactive roster, and master roster.

(b) "Active roster" means the list of individuals specific to an entity who have been determined eligible under this chapter to provide services for the entity and who the entity

has identified as affiliated. An individual shall remain on the entity's active roster and is considered affiliated until the commissioner determines the individual is ineligible or the entity removes the individual from the entity's active roster.

(c) "Inactive roster" means the list maintained by the commissioner of individuals who are eligible under this chapter to provide services and are not on an active roster. Individuals shall remain on the inactive roster for no more than 180 consecutive days, unless the individual submits a written request to the commissioner requesting to remain on the inactive roster for a longer period of time. Upon the commissioner's receipt of information that may cause an individual on the inactive roster to be disqualified under this chapter, the commissioner shall remove the individual from the inactive roster, and if the individual again seeks a position requiring a background study, the individual shall be required to complete a new background study.

(d) "Master roster" means the list maintained by the commissioner of all individuals who, as a result of a background study under this chapter, and regardless of affiliation with an entity, are determined by the commissioner to be eligible to provide services for one or more entities. The master roster includes all background study subjects on rosters under paragraphs (b) and (c).

Subd. 22. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician or advanced practice registered nurse, whether or not the care of a physician or advanced practice registered nurse was sought, or abuse resulting in serious injury.

(b) For purposes of this definition, "care of a physician or advanced practice registered nurse" is treatment received or ordered by a physician, physician assistant, advanced practice registered nurse, or nurse practitioner, but does not include:

(1) diagnostic testing, assessment, or observation;

(2) the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or

(3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment.

(c) For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and

other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke.

(d) Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

Subd. 23. **Subject of a background study.** "Subject of a background study" means an individual on whom a public law background study is required or completed.

Subd. 24. **Volunteer.** "Volunteer" means an individual who provides or seeks to provide services for an entity without compensation, is affiliated in NETStudy 2.0, and is subject to oversight by the entity, including but not limited to continuous, direct supervision and immediate removal from providing direct care services.

Sec. 23. **[245J.03] PUBLIC LAW BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.**

Subdivision 1. **Classification of public law background study data; access to information.** All data obtained by the commissioner for a background study completed under this chapter shall be classified as private data.

Subd. 2. **Minnesota Sex Offender Program.** The commissioner shall conduct a public law background study under this chapter for an employee having direct contact with persons civilly committed to the Minnesota Sex Offender Program operated by the commissioner under chapters 246B and 253D.

Sec. 24. **[245J.04] WHEN BACKGROUND STUDY MUST OCCUR.**

Subdivision 1. **Initial studies.** (a) An entity in section 245J.03 shall initiate a background study:

(1) for an individual in NETStudy 2.0, upon application for initial license. All license holders must be on the entity's active roster with a status of eligible, set aside, or variance granted;

(2) for a current or prospective employee in NETStudy 2.0, before the individual will have direct contact with persons receiving services; and

(3) for a volunteer in NETStudy 2.0, before the volunteer will have direct contact with persons served by the program, if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (2).

(b) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:

(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(3) the last study of the individual was conducted on or after October 1, 1995.

(c) Applicants for licensure, license holders, and entities as provided in this chapter must submit completed background study requests to the commissioner using NETStudy 2.0 before individuals specified in section 245J.03, subdivision 1, begin positions allowing direct contact in the program.

(d) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy 2.0 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 entity 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 entity, the previous set-aside shall remain in effect.

(e) For purposes of this section, a physician licensed under chapter 147 or an advanced practice registered nurse licensed under chapter 148 who is required to have a background study under this chapter is considered to be continuously affiliated upon the license holder's receipt from the commissioner of human services of the physician's or advanced practice registered nurse's background study results.

Subd. 2. **Public law background studies; electronic criminal case information updates; rosters; criteria for eliminating repeat background studies.** (a) The commissioner shall implement the electronic process in NETStudy 2.0 for the regular transfer of new criminal case information that is added to the Minnesota Court Information System. The commissioner's system must include for review only information that relates to individuals who are on the master roster.

(b) The commissioner shall develop and implement an online system as a part of NETStudy 2.0 for entities that initiate background studies under this chapter to access and maintain records of background studies initiated by that entity. The system must show all active background study subjects affiliated with that entity and the status of each individual's background study. Each entity that initiates background studies must use this system to notify the commissioner of discontinued affiliation for purposes of the processes required under paragraph (a).

Subd. 3. **New study required with legal name change.** (a) For a background study completed on an individual required to be studied under section 245J.03, the license holder or other entity that initiated the background study must initiate a new background study using NETStudy 2.0 when an individual who is affiliated with the license holder or other entity undergoes a legal name change.

(b) For background studies subject to a fee paid through NETStudy 2.0, the entity that initiated the study may initiate a new study under paragraph (a) or notify the commissioner of the name change through a notice to the commissioner.

(c) After an entity initiating a background study has paid the applicable fee for the study and has provided the individual with the privacy notice required under section 245J.05, subdivision 3, NETStudy 2.0 shall immediately inform the entity whether the individual requires a background study or whether the individual is immediately eligible to provide services based on a previous background study. If the individual is immediately eligible, the entity initiating the background study shall be able to view the information previously supplied by the individual who is the subject of a background study as required under section 245J.05, subdivision 1, including the individual's photograph taken at the time the individual's fingerprints were recorded. The commissioner shall not provide any entity initiating a subsequent background study with information regarding the other entities that initiated background studies on the subject.

(d) Verification that an individual is eligible to provide services based on a previous background study is dependent on the individual voluntarily providing the individual's

Social Security number to the commissioner at the time each background study is initiated. When an individual does not provide the individual's Social Security number for the background study, that study is not transferable and a repeat background study on that individual is required if the individual seeks a position requiring a background study under this chapter with another entity.

Sec. 25. **[245J.05] BACKGROUND STUDY; INFORMATION AND DATA PROVIDED TO COMMISSIONER.**

Subdivision 1. **Study submitted.** The entity with which the background study subject is seeking affiliation through employment, volunteering, or licensure shall initiate the background study in NETStudy 2.0.

Subd. 2. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245J.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number; and

(7) the home address, city, county, and state of residence for the past five years.

(b) The subject of a background study shall provide fingerprints and a photograph as required in subdivision 6.

Subd. 3. **Entity.** (a) The entity initiating a background study as provided in this chapter shall verify that the information collected under subdivision 1 about an individual who is the subject of the background study is correct and must provide the information on forms or in a manner prescribed by the commissioner.

(b) The information collected under subdivision 1 about an individual who is the subject of a completed background study may only be viewable by an entity that initiates a subsequent background study on that individual under NETStudy 2.0 after the entity has

paid the applicable fee for the study and has provided the individual with the privacy notice in subdivision 4.

Subd. 4. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy 2.0 system and shall include information that the individual has a disqualification that has been set aside for the entity that initiated the study.

(b) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, the Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints;

(2) the subject's photograph will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photograph will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) 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 subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245J.15, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the subject as provided in section 245J.15, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245J.06, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245J.06, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245J.06, paragraph (d).

Subd. 5. **Fingerprint data notification.** The commissioner of human services shall notify all background study subjects under this chapter that the Department of Human Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not retain fingerprint data after a background study is completed, and that the Federal Bureau of Investigation does not retain background study subjects' fingerprints.

Subd. 6. **Electronic transmission.** (a) The commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner; and

(2) background study results to the license holder.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245J.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

Subd. 7. **Fingerprints and photograph.** (a) Except as provided in paragraph (f), every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph. The photograph and fingerprints must be recorded at the same time by the authorized fingerprint collection vendor or vendors and sent to the commissioner through the commissioner's secure data system described in section 245J.29, subdivision 1a, paragraph (b).

(b) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal Apprehension and, when specifically required by law, submitted to the Federal Bureau of Investigation for a national criminal history record check.

(c) The fingerprints must not be retained by the Department of Public Safety, the Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints.

(d) 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, date, and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(e) For any background study conducted under this chapter, 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 245J.02, subdivision 13.

(f) A study subject is not required to submit fingerprints and a photograph for a new study if they currently have an eligible background study status on an active roster or on the master roster. The entity initiating the new study shall have access to the eligible status upon completion of the initiation and payment process.

(g) The commissioner may inform the entity that initiated the background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Subd. 8. **Applicant, license holder, and entity.** (a) The applicant, license holder, entity as provided in this chapter, Bureau of Criminal Apprehension, law enforcement agencies, commissioner of health, and county agencies shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults substantiated under section 626.557 and the maltreatment of minors substantiated under chapter 260E.

(b) If a background study is initiated by an applicant, license holder, or entity as provided in this chapter, and the applicant, license holder, or entity receives information about the possible criminal or maltreatment history of an individual who is the subject of the background study, the applicant, license holder, or entity must immediately provide the information to the commissioner.

(c) The applicant, license holder, entity, or county or other agency must provide written notice to the individual who is the subject of the background study of the requirements under this subdivision.

Subd. 9. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual:

(1) has been affiliated with a program or facility regulated by the Department of Human Services or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services within the preceding year; and

(2) has been convicted of a crime constituting a disqualification under section 245J.14.

(b) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(c) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes shall be reported to the commissioner by the corrections system.

(d) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(e) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245J.17, as appropriate, to entities on whose active rosters the study subject is affiliated.

Sec. 26. **[245J.06] DESTRUCTION OF BACKGROUND STUDY SUBJECT INFORMATION.**

(a) A background study subject may request in writing to the commissioner that information used to complete the individual's study in NETStudy 2.0 be destroyed if the individual:

(1) has not been affiliated with any entity for the previous two years; and

(2) has no current disqualifying characteristic.

(b) After receiving the request and verifying the information in paragraph (a), the commissioner shall destroy the information used to complete the subject's background study and shall keep a record of the subject's name and a notation of the date that the information was destroyed.

(c) When a previously studied individual has not been on the master roster for two years, the commissioner shall destroy the photographic image of the individual obtained under section 245J.05, subdivision 7, paragraph (a).

(d) Any data collected on an individual under this chapter that is maintained by the commissioner that has not been destroyed according to paragraph (b) or (c) shall be destroyed when two years have elapsed from the individual's actual death that is reported to the commissioner or when 90 years have elapsed since the individual's birth except when readily available data indicate that the individual is still living.

Sec. 27. **[245J.07] STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.**

(a) Subject to the conditions in paragraph (c), when a license holder, applicant, or other entity owns multiple programs or services that are licensed by the same agency, only one background study is required for an individual who provides direct contact services in one or more of the licensed programs or services if:

(1) the license holder designates one individual with one address and telephone number as the person to receive sensitive background study information for the multiple licensed programs or services that depend on the same background study; and

(2) the individual designated to receive the sensitive background study information is capable of determining, upon request of the department, whether a background study subject is providing direct contact services in one or more of the license holder's programs or services and, if so, at which location or locations.

(b) When a license holder maintains background study compliance for multiple licensed programs according to paragraph (a), and one or more of the licensed programs closes, the license holder shall immediately notify the commissioner which staff must be transferred to an active license so that the background studies can be electronically paired with the license holder's active program.

(c) For an entity operating under NETStudy 2.0, the entity's active roster must be the system used to document when a background study subject is affiliated with multiple entities. For a background study to be transferable:

(1) the background study subject must be on and moving to a roster for which the person designated to receive sensitive background study information is the same; and

(2) the same entity must own or legally control both the roster from which the transfer is occurring and the roster to which the transfer is occurring. For an entity that holds or

controls multiple entities, there must be a common highest level entity that has a legally identifiable structure that can be verified through records available from the secretary of state.

Sec. 28. **[245J.08] BACKGROUND STUDY; COMMISSIONER REVIEWS.**

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted under this chapter, the commissioner shall review:

(1) information related to findings of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) information related to findings of maltreatment of minors that has been received by the commissioner as required under chapter 260E;

(3) the commissioner's records relating to maltreatment in programs licensed by the Department of Human Services and the Department of Health;

(4) information from juvenile courts as required in subdivision 4 when there is reasonable cause;

(5) criminal history information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166; and

(6) information received as a result of a national criminal history record check, as defined in section 245J.02, subdivision 13, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245J.02, subdivision 16.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under this section, unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245J.04, subdivision 2, from the Minnesota Court Information System or Minnesota Government Access that relates to individuals who are being studied or have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

Subd. 2. **Arrest and investigative information.** (a) For any background study completed under this chapter, if the commissioner has reasonable cause to believe the information is

pertinent to the potential disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the commissioners of health and human services;

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from a national criminal history record check if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the entity that initiated the background study.

Subd. 3. **Juvenile court records.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review records from the juvenile courts for an individual studied under this chapter when the commissioner has reasonable cause.

(b) The juvenile courts shall help with the study by giving the commissioner existing juvenile court records relating to delinquency proceedings held on individuals studied under this chapter when requested pursuant to this subdivision.

(c) For purposes of this chapter, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

(d) Juvenile courts shall provide orders of involuntary and voluntary termination of parental rights under section 260C.301 to the commissioner upon request for purposes of conducting a background study under this chapter.

Sec. 29. **[245J.09] FAILURE OR REFUSAL TO COOPERATE WITH BACKGROUND STUDY.**

Subdivision 1. **Disqualification; licensing action.** An applicant's, license holder's, or other entity's failure or refusal to cooperate with the commissioner, including failure to provide additional information required under section 245J.05, is reasonable cause to disqualify a subject, deny a license application, or immediately suspend or revoke a license or registration.

Subd. 2. **Employment action.** An individual's failure or refusal to cooperate with the background study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended or revoked.

Sec. 30. **[245J.10] BACKGROUND STUDY; FEES.**

Subdivision 1. **Expenses.** Section 181.645 does not apply to background studies completed under this chapter.

Subd. 2. **Background study fees.** (a) The commissioner shall recover the cost of background studies. Except as otherwise provided in subdivisions 3 and 4, the fees collected under this section shall be appropriated to the commissioner for the purpose of conducting background studies under this chapter. Fees under this section are charges under section 16A.1283, paragraph (b), clause (3).

(b) Background study fees may include:

(1) a fee to compensate the commissioner's authorized fingerprint collection vendor or vendors for obtaining and processing a background study subject's classifiable fingerprints and photograph pursuant to subdivision 3; and

(2) a separate fee under subdivision 3 to complete a review of background-study-related records as authorized under this chapter.

(c) Fees charged under paragraph (b) may be paid in whole or in part when authorized by law by a state agency or board; by state court administration; by a service provider, employer, license holder, or other entity that initiates the background study; by the commissioner or other organization with duly appropriated funds; by a background study subject; or by some combination of these sources.

Subd. 3. **Fingerprint and photograph processing fees.** The commissioner shall enter into a contract with a qualified vendor or vendors to obtain and process a background study

subject's classifiable fingerprints and photograph as required by section 245J.05. The commissioner may, at their discretion, directly collect fees and reimburse the commissioner's authorized fingerprint collection vendor for the vendor's services or require the vendor to collect the fees. The authorized vendor is responsible for reimbursing the vendor's subcontractors at a rate specified in the contract with the commissioner.

Subd. 4. **National criminal history record check fees.** The commissioner may increase background study fees as necessary, commensurate with an increase in the national criminal history record check fee. The commissioner shall report any fee increase under this subdivision to the legislature during the legislative session following the fee increase, so that the legislature may consider adoption of the fee increase into statute. By July 1 of every year, background study fees shall be set at the amount adopted by the legislature under this section.

Subd. 5. **Minnesota Sex Offender Program.** The commissioner shall recover the cost of background studies for the Minnesota Sex Offender Program required under section 245J.03, subdivision 1, through a fee of no more than $42 per study charged to the entity submitting the study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 31. **[245J.11] BACKGROUND STUDY PROCESSING.**

Subdivision 1. **Completion of background study.** Upon receipt of the background study forms from an entity required to initiate a background study under this chapter, the commissioner shall complete the background study and provide the notice required under section 245J.15, subdivision 1.

Subd. 2. **Activities pending completion of background study.** (a) 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 (b).

(b) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245J.15 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 245J.15, 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;

(2) a notice that a disqualification has been set aside under section 245J.21; or

(3) a notice that a variance has been granted related to the individual under section 245J.27.

(c) Activities prohibited prior to receipt of notice under paragraph (b) include:

(1) being issued a license; or

(2) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision.

Subd. 3. **Other state information.** If the commissioner has not received criminal, sex offender, or maltreatment information from another state that is required to be reviewed under this chapter within ten days of requesting the information, and the lack of the information is the only reason that a notice is issued under subdivision 2, paragraph (b), clause (1), item (ii), the commissioner may issue a notice under subdivision 2, paragraph (b), clause (1), item (i). The commissioner may take action on information received from other states after issuing a notice under subdivision 2, paragraph (b), clause (1), item (ii).

Sec. 32. **[245J.12] DISQUALIFICATION.**

Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the entity identified in section 245J.03, upon receipt of information showing, or when a background study completed under this chapter shows any of the following:

(1) a conviction of, admission to, or Alford plea to one or more crimes listed in section 245J.13, regardless of whether the conviction or admission is a felony, gross misdemeanor, or misdemeanor level crime;

(2) a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245J.13, regardless of whether the preponderance of the evidence is for a felony, gross misdemeanor, or misdemeanor level crime;

(3) an investigation results in an administrative determination listed under section 245J.13, subdivision 4, paragraph (b); or

(4) involuntary termination of parental rights issued under subdivision 3 or section 260C.301, subdivision 1, paragraph (b).

(b) No individual who is disqualified following a background study under this chapter may be retained in a position involving direct contact with persons served by a program or entity identified in section 245J.03, unless the commissioner has provided written notice under section 245J.15 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245J.19, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that entity as provided in section 245J.20, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245J.27.

Subd. 2. **Disqualification from access.** (a) If an individual who is studied under this chapter is disqualified from direct contact under subdivision 1, the commissioner shall also disqualify the individual from access to a person receiving services from the entity.

(b) No individual who is disqualified following a background study under this chapter may be allowed access to persons served by the program unless the commissioner has provided written notice under section 245J.15 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245J.19, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that entity as provided in section 245J.20, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245J.27.

Sec. 33. **[245J.13] DISQUALIFYING CRIMES OR CONDUCT.**

Subdivision 1. **Permanent disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) regardless of how much time has passed since the discharge of the sentence imposed, if any, for the offense; and (2) unless otherwise specified, regardless of the level of the offense, the individual has committed any of the following offenses: sections 243.166 (violation of predatory offender registration law); 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); a felony

offense under 609.221 or 609.222 (assault in the first or second degree); 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); 609.228 (great bodily harm caused by distribution of drugs); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.322 (solicitation, inducement, and promotion of prostitution); 609.324, subdivision 1 (other prohibited acts); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.3458 (sexual extortion); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); a felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.66, subdivision 1e (drive-by shooting); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); 617.23, subdivision 2, clause (1), or subdivision 3, clause (1) (indecent exposure involving a minor); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors).

(b) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245J.12.

(c) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraph (a), permanently disqualifies the individual under section 245J.12.

(d) 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.

(e) If the individual studied commits one of the offenses listed in paragraph (a) that is specified as a felony-level only offense, but the sentence or level of offense is a gross

misdemeanor or misdemeanor, the individual is disqualified, but the disqualification look-back period for the offense is the period applicable to gross misdemeanor or misdemeanor offenses.

Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a felony-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal abuse of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 624.713 (certain persons not to possess firearms); chapter 152 (drugs; controlled substance); or Minnesota Statutes 2012, section 609.21; or a felony-level conviction involving alcohol or drug use.

(b) An individual is disqualified under section 245J.12 if less than 15 years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245J.12 if less than 15 years has passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or subdivision 3.

(d) An individual is disqualified under section 245J.12 if less than 15 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 the offenses listed in paragraph (a).

(e) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified but the disqualification look-back period for the offense is the period applicable to the gross misdemeanor or misdemeanor disposition.

(f) 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.

Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a gross misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft); 609.525

(bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); repeat offenses under 609.746 (interference with privacy); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01, subdivision 14.

(b) An individual is disqualified under section 245J.12 if less than ten years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245J.12 if less than ten 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 paragraph (a).

(d) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the offense is the period applicable to misdemeanors.

(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.

Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section 245J.12 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113,

or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic assault); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

(b) An individual is disqualified under section 245J.12 if less than seven years has passed since a determination or disposition of the individual's:

(1) failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.557 or chapter 260E was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

(2) substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.557 or chapter 260E for which: (i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245J.12 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 245J.12 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 245J.12 if less than seven years has passed since the individual was disqualified under section 256.98, subdivision 8.

Sec. 34. **[245J.14] DISQUALIFIED INDIVIDUAL'S RISK OF HARM.**

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 245J.22, 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 entity; and

(c) 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.

Subd. 2. **Findings.** (a) After evaluating the information immediately available under subdivision 1, the commissioner may have reason to believe one of the following:

(1) the individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact or access to persons served by the entity or where the individual studied will work;

(2) the individual poses a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration; or

(3) the individual does not pose an imminent risk of harm or a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration.

(b) After determining an individual's risk of harm under this section, the commissioner must notify the subject of the background study and the applicant or license holder as required under section 245J.15.

Sec. 35. **[245J.15] NOTICE OF BACKGROUND STUDY RESULTS.**

Subdivision 1. **Time frame for notice of study results and auditing system access.** (a) Within three working days after the commissioner's receipt of a request for a background study submitted through the commissioner's NETStudy 2.0 system, the commissioner shall notify the background study subject and the entity that submitted the study in writing or by electronic transmission of the results of the study or that more time is needed to complete the study. The notice to the individual shall include the identity of the entity that initiated the background study.

(b) Before being provided access to NETStudy 2.0, the entity shall sign an acknowledgment of responsibilities form developed by the commissioner that includes identifying the sensitive background study information person, who must be an employee of the entity. All queries to NETStudy 2.0 are electronically recorded and subject to audit by the commissioner. The electronic record shall identify the specific user. A background

study subject may request in writing to the commissioner a report listing the entities that initiated a background study on the individual.

(c) When the commissioner has completed a prior background study on an individual that resulted in an order for immediate removal and more time is necessary to complete a subsequent study, the notice that more time is needed that is issued under paragraph (a) shall include an order for immediate removal of the individual from any position allowing direct contact with or access to people receiving services.

Subd. 2. **Disqualification notice sent to subject.** If the information in the study indicates the individual is disqualified from direct contact with, or from access to, persons served by the program, the commissioner shall disclose to the individual studied:

(1) the information causing disqualification;

(2) instructions on how to request a reconsideration of the disqualification;

(3) an explanation of any restrictions on the commissioner's discretion to set aside the disqualification under section 245J.22, when applicable to the individual; and

(4) a statement that when a subsequent background study is initiated on the individual following a set-aside of the individual's disqualification, and the commissioner makes a determination under section 245J.20, subdivision 5, paragraph (b), that the previous set-aside applies to the subsequent background study, the entity that initiated the background study will be informed that the individual's disqualification is set aside for that entity.

Subd. 3. **Disqualification notification.** (a) The commissioner shall notify the entity that submitted the study:

(1) that the commissioner has found information that disqualifies the individual studied from being in a position allowing direct contact with, or access to, people served by the entity; and

(2) the commissioner's determination of the individual's risk of harm under section 245J.14.

(b) If the commissioner determines under section 245J.14 that an individual studied poses an imminent risk of harm to persons served by the entity where the individual studied will have direct contact with, or access to, people served by the entity, the commissioner shall order the license holder to immediately remove the individual studied from any position allowing direct contact with, or access to, people served by the entity.

(c) If the commissioner determines under section 245J.14 that an individual studied poses a risk of harm that requires continuous, direct supervision, the commissioner shall order the entity to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in a position allowing direct contact with, or access to, people receiving services, the entity must:

(i) ensure that the individual studied is under continuous, direct supervision when in a position allowing direct contact with, or access to, people receiving services during the period in which the individual may request a reconsideration of the disqualification under section 245J.19; and

(ii) ensure that the disqualified individual requests reconsideration within 30 days of receipt of the notice of disqualification.

(d) If the commissioner determines under section 245J.14 that an individual studied does not pose a risk of harm that requires continuous, direct supervision, the commissioner shall order the entity to:

(1) immediately remove the individual studied from any position allowing direct contact with, or access to, people receiving services; or

(2) before allowing the disqualified individual to be in any position allowing direct contact with, or access to, people receiving services, the entity must ensure that the disqualified individual requests reconsideration within 15 days of receipt of the notice of disqualification.

(e) The commissioner shall not notify the entity of the information contained in the subject's background study unless:

(1) the basis for the disqualification is failure to cooperate with the background study or substantiated maltreatment under section 626.557 or chapter 260E;

(2) the Data Practices Act under chapter 13 provides for release of the information; or

(3) the individual studied provides the commissioner with written, informed consent authorizing the release of the information.

Sec. 36. **[245J.16] OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM DIRECT CONTACT OR ACCESS TO PEOPLE RECEIVING SERVICES.**

Upon receipt of notice from the commissioner, the entity must remove a disqualified individual from direct contact with or access to persons served by the entity if:

(1) the individual does not request reconsideration under section 245J.19 within the prescribed time;

(2) the individual submits a timely request for reconsideration, the commissioner does not set aside the disqualification under section 245J.20, subdivision 4, and the individual does not submit a timely request for a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14; or

(3) the individual submits a timely request for a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14, and the commissioner does not set aside or rescind the disqualification under section 245A.08, subdivision 5, or 256.045.

Sec. 37. **[245J.17] TERMINATION OF AFFILIATION BASED ON DISQUALIFICATION NOTICE.**

An applicant or license holder that terminates affiliation with persons studied under this chapter, when the termination is made in good faith reliance on a notice of disqualification provided by the commissioner, shall not be subject to civil liability.

Sec. 38. **[245J.18] ENTITY RECORD KEEPING.**

Subdivision 1. **Background studies initiated by entity.** The entity shall document the date the entity initiates a background study under this chapter and the date the subject of the study first has direct contact with persons served by the entity in the entity's personnel files. When a background study is completed under this chapter, an entity shall maintain a notice that the study was undertaken and completed in the entity's personnel files.

Subd. 2. **Background studies initiated by others; personnel pool agencies, temporary personnel agencies, supplemental nursing services agencies, or professional services agencies.** When a license holder relies on a background study initiated by a personnel pool agency, a temporary personnel agency, a supplemental nursing services agency, or a professional services agency for a person required to have a background study completed under this chapter, the entity must maintain a copy of the background study results in the entity's files.

Subd. 3. **Background studies initiated by others; educational programs.** When an entity relies on a background study initiated by an educational program for a person required to have a background study completed under this chapter and the person is on the educational program's active roster, the entity is responsible for ensuring that the background study has been completed. The entity may satisfy the documentation requirements through a written agreement with the educational program verifying that documentation of the background study may be provided upon request and that the educational program will inform the entity if there is a change in the person's background study status. The entity remains responsible for ensuring that all background study requirements are met.

Subd. 4. **Background studies identified on active rosters.** The requirements in subdivisions 1 and 2 are met for entities for which active rosters are implemented and for whom all individuals affiliated with the entity are recorded on the active roster.

Sec. 39. **[245J.19] REQUESTING RECONSIDERATION OF DISQUALIFICATION.**

Subdivision 1. **Who may request reconsideration.** An individual who is the subject of a disqualification may request a reconsideration of the disqualification pursuant to this section. The individual must submit the request for reconsideration to the commissioner in writing.

Subd. 2. **Submission of reconsideration request.** A reconsideration request shall be submitted within 30 days of the individual's receipt of the disqualification notice or the time frames specified in subdivision 3, whichever time frame is shorter.

Subd. 3. **Time frame for requesting reconsideration.** (a) When the commissioner sends an individual a notice of disqualification based on a finding under section 245J.14, subdivision 2, paragraph (a), clause (1) or (2), the disqualified individual must submit the request for a reconsideration within 30 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 30 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 30 calendar days after the individual's receipt of the notice of disqualification. Upon showing that the information under subdivision 3 cannot be obtained within 30 days, the disqualified individual may request additional time, not to exceed 30 days, to obtain the information.

(b) When the commissioner sends an individual a notice of disqualification based on a finding under section 245J.14, subdivision 2, paragraph (a), clause (3), the disqualified individual must submit the request for reconsideration within 15 calendar days of the

individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 15 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 15 calendar days after the individual's receipt of the notice of disqualification.

(c) An individual who was determined to have maltreated a child under chapter 260E or a vulnerable adult under section 626.557, and who is disqualified on the basis of serious or recurring maltreatment, may request a reconsideration of both the maltreatment and the disqualification determinations. The request must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 30 calendar days of the individual's receipt of the notice of disqualification. If a request for reconsideration is made by personal service, it must be received by the commissioner within 30 calendar days after the individual's receipt of the notice of disqualification.

(d) Reconsideration of a maltreatment determination under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of a disqualification under section 245J.20, shall not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination, disqualification, and denial of a license or licensing sanction. In such cases, a fair hearing under section 256.045 must not be conducted under sections 245J.24, 260E.33, and 626.557, subdivision 9d. Under section 245A.08, subdivision 2a, the scope of the consolidated contested case hearing must include the maltreatment determination, disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245J.20. In such cases, a fair hearing shall also be conducted as provided under sections 245J.24, 260E.33, and 626.557, subdivision 9d.

Subd. 4. **Disqualified individuals; information for reconsideration.** (a) The disqualified individual requesting reconsideration must submit information showing that:

(1) the information the commissioner relied upon in determining the underlying conduct that gave rise to the disqualification is incorrect;

(2) for maltreatment, the information the commissioner relied upon in determining that maltreatment was serious or recurring is incorrect; or

(3) the subject of the study does not pose a risk of harm to any person served by the entity as provided in this chapter, by addressing the information required under section 245J.20, subdivision 4.

(b) In order to determine the individual's risk of harm, the commissioner may require additional information from the disqualified individual as part of the reconsideration process. If the individual fails to provide the required information, the commissioner may deny the individual's request.

Subd. 5. **Notice of request for reconsideration.** Upon request, the commissioner may inform the entity as provided in this chapter who received a notice of the individual's disqualification under section 245J.15, subdivision 3, or has the consent of the disqualified individual, whether the disqualified individual has requested reconsideration.

Sec. 40. **[245J.20] REVIEW AND ACTION ON A RECONSIDERATION REQUEST.**

Subdivision 1. **Time frame; response to disqualification reconsideration requests.** (a) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information the commissioner relied upon to disqualify is incorrect or inaccurate within 30 working days of receipt of a complete request and all required relevant information.

(b) If the basis for a disqualified individual's reconsideration request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving a complete request for reconsideration and all required relevant information.

(c) If the disqualified individual's reconsideration request is based on both the correctness or accuracy of the information the commissioner relied upon to disqualify the individual and the individual's risk of harm, the commissioner shall respond to the request within 45 working days after receiving a complete request for reconsideration and all required relevant information.

Subd. 2. **Incorrect information; rescission.** The commissioner shall rescind the disqualification if the commissioner finds that the information relied upon to disqualify the subject is incorrect.

Subd. 3. **Preeminent weight given to safety of persons being served.** In reviewing a request for reconsideration of a disqualification, the commissioner shall give preeminent weight to the safety of each person served by the entity as provided in this chapter over the interests of the disqualified individual or entity as provided in this chapter, and any single factor under subdivision 4, paragraph (b), may be determinative of the commissioner's decision whether to set aside the individual's disqualification.

Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the entity as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

(1) the nature, severity, and consequences of the event or events that led to the disqualification;

(2) whether there is more than one disqualifying event;

(3) the age and vulnerability of the victim at the time of the event;

(4) the harm suffered by the victim;

(5) vulnerability of persons served by the program;

(6) the similarity between the victim and persons served by the program;

(7) the time elapsed without a repeat of the same or similar event;

(8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

(9) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245J.21. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245J.04, subdivision 1, paragraph (c), if an 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.

(b) If the commissioner has previously set aside an individual's disqualification for one or more entities, and the individual is the subject of a subsequent background study for a different entity, the commissioner shall determine whether the disqualification is set aside for the entity that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with an entity licensed or regulated under the same provisions of law and rule for at least one entity for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245J.13, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245J.15, in addition to the requirements under section 245J.15, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245J.19 on the basis that the information used to disqualify the individual is incorrect.

Subd. 6. **Rescission of set-aside.** The commissioner may rescind a previous set aside of a disqualification under this section based on new information that indicates the individual may pose a risk of harm to persons served by the applicant, license holder, or other entities as provided in this chapter. If the commissioner rescinds a set-aside of a disqualification

under this subdivision, the appeal rights under sections 245J.19; 245J.24, subdivision 1; and 245J.25, subdivision 3, shall apply.

Sec. 41. **[245J.21] COMMISSIONER'S RECONSIDERATION NOTICE.**

Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner rescinds or sets aside a disqualification, the commissioner shall notify the entity in writing or by electronic transmission of the decision.

(b) In the notice from the commissioner that a disqualification has been rescinded, the commissioner must inform the entity that the information relied upon to disqualify the individual was incorrect.

Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The commissioner shall notify the entity of the disqualification and order the entity to immediately remove the individual from any position allowing direct contact with persons receiving services from the entity if:

(1) the individual studied does not submit a timely request for reconsideration under section 245J.19;

(2) the individual submits a timely request for reconsideration, but the commissioner does not set aside the disqualification for that entity under section 245J.20, unless the individual has a right to request a hearing under section 245J.24, 245J.25, or 256.045;

(3) an individual who has a right to request a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14 for a disqualification that has not been set aside, does not request a hearing within the specified time; or

(4) an individual submitted a timely request for a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14, but the commissioner does not set aside the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) If the commissioner does not set aside the disqualification under section 245J.20, and the entity was previously ordered under section 245J.15 to immediately remove the disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the order remains in effect pending the outcome of a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14.

(c) If the commissioner does not set aside the disqualification under section 245J.20, and the entity was not previously ordered under section 245J.15 to immediately remove the

disqualified individual from direct contact with persons receiving services or to ensure that the individual is under continuous direct supervision when providing direct contact services, the commissioner shall order the individual to remain under continuous direct supervision pending the outcome of a hearing under sections 245J.24 and 256.045, or 245J.25 and chapter 14.

Sec. 42. **[245J.22] DISQUALIFICATION; BAR TO SET ASIDE A DISQUALIFICATION.**

The commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245J.13, subdivision 1.

Sec. 43. **[245J.23] CONSOLIDATED RECONSIDERATION OF MALTREATMENT DETERMINATION AND DISQUALIFICATION.**

If an individual is disqualified on the basis of a determination of maltreatment under section 626.557 or chapter 260E, which was serious and recurring, and the individual requests reconsideration of the maltreatment determination under section 260E.33 or 626.557, subdivision 9d, and also requests reconsideration of the disqualification under section 245J.19, the commissioner shall consolidate the reconsideration of the maltreatment determination and the disqualification into a single reconsideration.

Sec. 44. **[245J.24] FAIR HEARING RIGHTS.**

Subdivision 1. **Fair hearing following a reconsideration decision.** (a) An individual who is disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in section 245J.13; for a determination under section 626.557 or chapter 260E of substantiated maltreatment that was serious or recurring under section 245J.13; or for failure to make required reports under section 260E.06, subdivision 1 or 2; 260E.11, subdivision 1; or 626.557, subdivision 3, pursuant to section 245J.13, subdivision 4, paragraph (b), clause (1), may request a fair hearing under section 256.045, following a reconsideration decision issued under section 245J.21, unless the disqualification is deemed conclusive under section 245J.26.

(b) The fair hearing is the only administrative appeal of the final agency determination for purposes of appeal by the disqualified individual. The disqualified individual does not have the right to challenge the accuracy and completeness of data under section 13.04.

(c) Except as provided under paragraph (e), if the individual was disqualified based on a conviction of, admission to, or Alford Plea to any crimes or conduct listed in section 245J.13, subdivisions 1 to 4, or for a disqualification under section 256.98, subdivision 8, the reconsideration decision under section 245J.20 is the final agency determination for purposes of appeal by the disqualified individual and is not subject to a hearing under section 256.045. If the individual was disqualified based on a judicial determination, that determination is treated the same as a conviction for purposes of appeal.

(d) This subdivision does not apply to a public employee's appeal of a disqualification under section 245J.25, subdivision 3.

(e) Notwithstanding paragraph (c), if the commissioner does not set aside a disqualification of an individual who was disqualified based on both a preponderance of evidence and a conviction or admission, the individual may request a fair hearing under section 256.045, unless the disqualifications are deemed conclusive under section 245J.26. The scope of the hearing conducted under section 256.045 with regard to the disqualification based on a conviction or admission shall be limited solely to whether the individual poses a risk of harm, according to section 256.045, subdivision 3b. In this case, the reconsideration decision under section 245J.20 is not the final agency decision for purposes of appeal by the disqualified individual.

Subd. 2. **Consolidated fair hearing following a reconsideration decision.** (a) If an individual who is disqualified on the bases of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 260E.33 or 626.557, subdivision 9d, and requests a fair hearing under this section on the disqualification following a reconsideration decision under section 245J.21, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification.

(b) A fair hearing is the only administrative appeal of the final agency determination. The disqualified individual does not have the right to challenge the accuracy and completeness of data under section 13.04.

(c) This subdivision does not apply to a public employee's appeal of a disqualification under section 245J.25, subdivision 3.

Sec. 45. **[245J.25] CONTESTED CASE HEARING RIGHTS.**

Subdivision 1. **License holder.** (a) If a maltreatment determination or a disqualification for which reconsideration was timely requested and which was not set aside is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07,

the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder must submit the appeal under section 245A.05 or 245A.07, subdivision 3.

(b) As provided under section 245A.08, subdivision 2a, if the denial of a license or licensing sanction is based on a disqualification for which reconsideration was timely requested and was not set aside, the scope of the consolidated contested case hearing must include:

(1) the disqualification, to the extent the license holder otherwise has a hearing right on the disqualification under this chapter; and

(2) the licensing sanction or denial of a license.

(c) As provided for under section 245A.08, subdivision 2a, if the denial of a license or licensing sanction is based on a determination of maltreatment under section 626.557 or chapter 260E, or a disqualification for serious or recurring maltreatment which was not set aside, the scope of the contested case hearing must include:

(1) the maltreatment determination, if the maltreatment is not conclusive under section 245J.26;

(2) the disqualification, if the disqualification is not conclusive under section 245J.26; and

(3) the licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. If the disqualification was based on a determination of substantiated serious or recurring maltreatment under section 626.557 or chapter 260E, the appeal must be submitted under section 245A.07, subdivision 3, 260E.33, or 626.557, subdivision 9d.

(d) Except for family child care and child foster care, reconsideration of a maltreatment determination under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of a disqualification under section 245J.20, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination, disqualification, and denial of a license or licensing sanction. In such cases a fair hearing under section 256.045 must not be conducted under sections 245J.24, 260E.33, and 626.557, subdivision 9d. Under section 245A.08, subdivision 2a, the scope of the consolidated contested case hearing must include the maltreatment determination, disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 260E.33 and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245J.20. In such cases, a fair hearing shall also be conducted as provided under sections 245J.24, 260E.33, and 626.557, subdivision 9d.

Subd. 2. **Individual other than license holder.** If the basis for the commissioner's denial of a license under section 245A.05 or a licensing sanction under section 245A.07 is a maltreatment determination or disqualification that was not set aside under section 245J.20, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under this chapter, the hearing of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

Subd. 3. **Employees of public employer.** (a) A disqualified individual who is an employee of an employer, as defined in section 179A.03, subdivision 15, may request a contested case hearing under chapter 14, and specifically Minnesota Rules, parts 1400.8505 to 1400.8612, following a reconsideration decision under section 245J.21, unless the disqualification is deemed conclusive under section 245J.26. The request for a contested case hearing must be made in writing and must be postmarked and sent within 30 calendar days after the employee receives notice of the reconsideration decision. If the individual was disqualified based on a conviction or admission to any crimes listed in section 245J.13, the scope of the contested case hearing shall be limited solely to whether the individual poses a risk of harm pursuant to section 245J.20.

(b) When an individual is disqualified based on a maltreatment determination, the scope of the contested case hearing under paragraph (a), must include the maltreatment determination and the disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

(c) Rules adopted under this chapter may not preclude an employee in a contested case hearing for a disqualification from submitting evidence concerning information gathered under this chapter.

(d) When an individual has been disqualified from multiple licensed programs, if at least one of the disqualifications entitles the person to a contested case hearing under this subdivision, the scope of the contested case hearing shall include all disqualifications from licensed programs.

(e) In determining whether the disqualification should be set aside, the administrative law judge shall consider all of the characteristics that cause the individual to be disqualified, as well as all the factors set forth in section 245J.20, in order to determine whether the individual has met the burden of demonstrating that the individual does not pose a risk of harm. The administrative law judge's recommendation and the commissioner's order to set aside a disqualification that is the subject of the hearing constitutes a determination that the individual does not pose a risk of harm and that the individual may provide direct contact services in the individual program specified in the set aside.

(f) An individual may not request a contested case hearing under this section if a contested case hearing has previously been held regarding the individual's disqualification on the same basis.

Subd. 4. **Final agency order.** The commissioner's final order under section 245A.08, subdivision 5, is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent background studies. The contested case hearing under this section is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

Sec. 46. **[245J.26] CONCLUSIVE DETERMINATIONS OR DISPOSITIONS.**

Subdivision 1. **Conclusive maltreatment determination or disposition.** Unless otherwise specified in statute, a maltreatment determination or disposition under section 626.557 or chapter 260E is conclusive, if:

(1) the commissioner has issued a final order in an appeal of that determination or disposition under section 245A.08, subdivision 5, or 256.045;

(2) the individual did not request reconsideration of the maltreatment determination or disposition under section 626.557 or chapter 260E; or

(3) the individual did not request a hearing of the maltreatment determination or disposition under section 256.045.

Subd. 2. **Conclusive disqualification determination.** (a) A disqualification is conclusive for purposes of current and future background studies if:

(1) the commissioner has issued a final order in an appeal of the disqualification under section 245A.08, subdivision 5; 245J.25, subdivision 3; or 256.045, or a court has issued a final decision;

(2) the individual did not request reconsideration of the disqualification under section 245J.19 on the basis that the information relied upon to disqualify the individual was incorrect; or

(3) the individual did not timely request a hearing on the disqualification under this chapter, chapter 14, or section 256.045 after previously being given the right to do so.

(b) If a disqualification is conclusive under this section, the individual has a right to request reconsideration on the risk of harm under section 245J.19 unless the commissioner is barred from setting aside the disqualification under section 245J.22. The commissioner's decision regarding the risk of harm shall be the final agency decision and is not subject to a hearing under this chapter, chapter 14, or section 256.045.

Sec. 47. **[245J.27] VARIANCE FOR A DISQUALIFIED INDIVIDUAL.**

Subdivision 1. **Entity variance.** (a) Except for any disqualification under section 245J.11, subdivision 1, when the commissioner has not set aside a background study subject's disqualification, and there are conditions under which the disqualified individual may provide direct contact services or have access to people receiving services that minimize the risk of harm to people receiving services, the commissioner may grant a time-limited variance to an entity.

(b) The variance shall state the services that may be provided by the disqualified individual and state the conditions with which the entity must comply for the variance to remain in effect. The variance shall not state the reason for the disqualification.

Subd. 2. **Consequences for failing to comply with conditions of variance.** When an entity permits a disqualified individual to provide any services for which the subject is disqualified without complying with the conditions of the variance, the commissioner may terminate the variance effective immediately and subject the entity or license holder to a licensing action under sections 245A.06 and 245A.07.

Subd. 3. **Termination of a variance.** The commissioner may terminate a variance for a disqualified individual at any time for cause.

Subd. 4. **Final decision.** The commissioner's decision to grant or deny a variance is final and not subject to appeal under the provisions of chapter 14.

Sec. 48. **[245J.28] INDIVIDUAL REGULATED BY A HEALTH-RELATED LICENSING BOARD; DISQUALIFICATION BASED ON MALTREATMENT.**

(a) The commissioner has the authority to monitor the facility's compliance with any requirements that the health-related licensing board places on regulated individuals practicing in a facility either during the period pending a final decision on a disciplinary or corrective action or as a result of a disciplinary or corrective action. The commissioner has the authority to order the immediate removal of a regulated individual from direct contact or access when a board issues an order of temporary suspension based on a determination that the regulated individual poses an immediate risk of harm to persons receiving services in a licensed facility.

(b) A facility that allows a regulated individual to provide direct contact services while not complying with the requirements imposed by the health-related licensing board is subject to action by the commissioner as specified under sections 245A.06 and 245A.07.

(c) The commissioner shall notify a health-related licensing board immediately upon receipt of knowledge of a facility's or individual's noncompliance with requirements the board placed on a facility or upon an individual regulated by the board.

Sec. 49. **[245J.29] SYSTEMS AND RECORDS.**

Subdivision 1. **Establishment.** The commissioner may establish systems and records to fulfill the requirements of this chapter.

Subd. 2. **NETStudy 2.0 system.** (a) The NETStudy 2.0 system developed and implemented by the commissioner shall incorporate and meet all applicable data security standards and policies required by the Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal Apprehension, and Department of Information Technology Services. The system shall meet all required standards for encryption of data at the database level as well as encryption of data that travels electronically among agencies initiating background studies, the commissioner's authorized fingerprint collection vendor or vendors, the commissioner, the Bureau of Criminal Apprehension, and in cases involving national criminal record checks, the FBI.

(b) The data system developed and implemented by the commissioner shall incorporate a system of data security that allows the commissioner to control access to the data field

level by the commissioner's employees. The commissioner shall establish that employees have access to the minimum amount of private data on any individual as is necessary to perform their duties under this chapter.

(c) The commissioner shall oversee regular quality and compliance audits of the authorized fingerprint collection vendor or vendors.

Subd. 3. **Use.** The commissioner may also use these systems and records to obtain and provide criminal history data from the Bureau of Criminal Apprehension, criminal history data held by the commissioner, and data about substantiated maltreatment under section 626.557 or chapter 260E, for other purposes, provided that the background study is specifically authorized in statute.

Subd. 4. **National records search.** (a) When specifically required by statute, the commissioner shall also obtain criminal history data from the National Criminal Records Repository.

(b) To obtain criminal history data from the National Criminal Records Repository, the commissioner shall require classifiable fingerprints of the data subject and must submit these fingerprint requests through the Bureau of Criminal Apprehension.

(c) The commissioner may require the background study subject to submit fingerprint images electronically. The commissioner may not require electronic fingerprint images until the electronic recording and transfer system is available for noncriminal justice purposes and the necessary equipment is in use in the law enforcement agency in the background study subject's local community.

(d) The commissioner may recover the cost of obtaining and providing criminal history data from the National Criminal Records Repository by charging the individual or entity requesting the study a fee of no more than $30 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of obtaining criminal history data from the National Criminal Records Repository.

Sec. 50. **REPEALER.**

Minnesota Statutes 2022, sections 245C.02, subdivision 14b; 245C.032; and 245C.30, subdivision 1a, are repealed.

ARTICLE 13
LICENSING

Section 1. Minnesota Statutes 2022, section 245.095, is amended to read:

245.095 LIMITS ON RECEIVING PUBLIC FUNDS.

Subdivision 1. **Prohibition.** (a) If a provider, vendor, or individual enrolled, licensed, receiving funds under a grant contract, or registered in any program administered by the commissioner, including under the commissioner's powers and authorities in section 256.01, is excluded from that program, the commissioner shall:

(1) prohibit the excluded provider, vendor, or individual from enrolling, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner; and

(2) disenroll, revoke or suspend a license, disqualify, or debar the excluded provider, vendor, or individual in any other program administered by the commissioner.

(b) If a provider, vendor, or individual enrolled, licensed, receiving funds under a grant contract, or registered in any program administered by the commissioner, including under the commissioner's powers and authorities in section 256.01, is excluded from that program, the commissioner may:

(1) prohibit any associated entities or associated individuals from enrolling, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner; and

(2) disenroll, revoke or suspend a license of, disqualify, or debar any associated entities or associated individuals in any other program administered by the commissioner.

(c) If a provider, vendor, or individual enrolled, licensed, or otherwise receiving funds under any contract or registered in any program administered by a Minnesota state or federal agency is excluded from that program, the commissioner of human services may:

(1) prohibit the excluded provider, vendor, individual, or any associated entities or associated individuals from enrolling, becoming licensed, receiving grant funds, or registering in any program administered by the commissioner; and

(2) disenroll, revoke or suspend a license of, disqualify, or debar the excluded provider, vendor, individual, or any associated entities or associated individuals in any program administered by the commissioner.

~~(b)~~ (d) The duration of ~~this~~ a prohibition, disenrollment, revocation, suspension, disqualification, or debarment under paragraph (a) must last for the longest applicable sanction or disqualifying period in effect for the provider, vendor, or individual permitted by state or federal law. The duration of a prohibition, disenrollment, revocation, suspension, disqualification, or debarment under paragraphs (b) and (c) may last until up to the longest applicable sanction or disqualifying period in effect for the provider, vendor, individual, associated entity, or associated individual as permitted by state or federal law.

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

(b) "Associated entity" means a provider or vendor owned or controlled by an excluded individual.

(c) "Associated individual" means an individual who owns or is an executive officer or board member of an excluded provider or vendor.

~~(b)~~ (d) "Excluded" means ~~disenrolled, disqualified, having a license that has been revoked or suspended under chapter 245A, or debarred or suspended under Minnesota Rules, part 1230.1150, or excluded pursuant to section 256B.064, subdivision 3~~ removed under other authorities from a program administered by a Minnesota state or federal agency, including a final determination to stop payments.

~~(c)~~ (e) "Individual" means a natural person providing products or services as a provider or vendor.

~~(d)~~ (f) "Provider" ~~includes any entity or individual receiving payment from a program administered by the Department of Human Services, and an owner, controlling individual, license holder, director, or managerial official of an entity receiving payment from a program administered by the Department of Human Services~~ means any entity, individual, owner, controlling individual, license holder, director, or managerial official of an entity receiving payment from a program administered by a Minnesota state or federal agency.

Subd. 3. **Notice.** Within five days of taking an action under subdivision (1), paragraph (a), (b), or (c), against a provider, vendor, individual, associated individual, or associated entity, the commissioner must send notice of the action to the provider, vendor, individual, associated individual, or associated entity. The notice must state:

(1) the basis for the action;

(2) the effective date of the action;

(3) the right to appeal the action; and

(4) the requirements and procedures for reinstatement.

Subd. 4. **Appeal.** Upon receipt of a notice under subdivision 3, a provider, vendor, individual, associated individual, or associated entity may request a contested case hearing, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The scope of any contested case hearing is solely limited to action taken under this section. The commissioner must receive the appeal request no later than 30 days after the date the notice was mailed to the provider, vendor, individual, associated individual, or associated entity. The appeal request must specify:

(1) each disputed item and the reason for the dispute;

(2) the authority in statute or rule upon which the provider, vendor, individual, associated individual, or associated entity relies for each disputed item;

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

(4) any other information required by the commissioner.

Subd. 5. **Withholding of payments.** (a) Except as otherwise provided by state or federal law, the commissioner may withhold payments to a provider, vendor, individual, associated individual, or associated entity in any program administered by the commissioner, if the commissioner determines there is a credible allegation of fraud for which an investigation is pending for a program administered by a Minnesota state or federal agency.

(b) For purposes of this subdivision, "credible allegation of fraud" means an allegation that has been verified by the commissioner from any source, including but not limited to:

(1) fraud hotline complaints;

(2) claims data mining;

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

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

(c) The commissioner must send notice of the withholding of payments within five days of taking such action. The notice must:

(1) state that payments are being withheld according to this subdivision;

(2) set forth the general allegations related to the withholding action, except the notice need not disclose specific information concerning an ongoing investigation;

(3) state that the withholding is for a temporary period and cite the circumstances under which the withholding will be terminated; and

(4) inform the provider, vendor, individual, associated individual, or associated entity of the right to submit written evidence to contest the withholding action for consideration by the commissioner.

(d) The commissioner shall stop withholding payments if the commissioner determines there is insufficient evidence of fraud by the provider, vendor, individual, associated individual, or associated entity or when legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice under subdivision 3 to the provider, vendor, individual, associated individual, or associated entity.

(e) The withholding of payments is a temporary action and is not subject to appeal under section 256.045 or chapter 14.

Sec. 2. **[245.7351] PURPOSE AND 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 diagnosed with behavioral health disorders while achieving sustainable rates for providers and economic efficiencies for payors.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. **[245.7352] DEFINITIONS.**

Subdivision 1. **Scope.** The definitions in this section apply to sections 245.7351 to 245.736.

Subd. 2. **Approval.** "Approval" has the meaning given in section 245I.02, subdivision 2.

Subd. 3. **Care coordination.** "Care coordination" means the activities required to coordinate care across settings and providers for the people 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 to primary care practitioners and mental health clinical care consultation.

Subd. 4. **Certified community behavioral health clinic or CCBHC.** "Certified community behavioral health clinic" or "CCBHC" means a program or provider governed under sections 245.7351 to 245.736.

Subd. 5. **Clinical responsibility.** "Clinical responsibility" means ensuring a designated collaborating organization meets all clinical parameters required of the CCBHC.

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 7. **Comprehensive evaluation.** "Comprehensive evaluation" means a person-centered, family-centered, trauma-informed evaluation completed for the purposes of diagnosis, treatment planning, and determination of client eligibility for services approved by a mental health professional.

Subd. 8. **Crisis services.** "Crisis services" means crisis mental health and substance use services, including 24-hour mobile crisis teams, emergency crisis intervention services, crisis stabilization through existing mobile crisis services, and ambulatory withdrawal management services equal to the American Society of Addiction Medicine's levels of care 1.0 or 2.0.

Subd. 9. **Cultural and linguistic competence.** "Cultural and linguistic competence" means appropriate services are respectful of and responsive to the health beliefs, practices, and needs of diverse individuals.

Subd. 10. **Designated collaborating organization.** "Designated collaborating organization" means an entity with a formal agreement with a CCBHC to furnish CCBHC services.

Subd. 11. **Designated collaborating organization agreement.** "Designated collaborating organization agreement" means a purchase of services agreement between a CCBHC and a designated collaborating organization as evidenced by a contract, memorandum of agreement, memorandum of understanding, or other such formal arrangement that describes specific CCBHC services to be purchased and provided by a designated collaborating organization on behalf of a CCBHC in accordance with federal and state requirements.

Subd. 12. **Face to face.** "Face to face" means two-way, real-time, interactive and visual communication between a client and a treatment service provider, including services delivered in person or via telehealth.

Subd. 13. **Functional assessment.** "Functional assessment" means the assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age.

The CCBHC functional assessment requirements replace the requirements in:

(1) section 256B.0623, subdivision 9;

(2) section 245.4711, subdivision 3; and

(3) Minnesota Rules, part 9520.0914, subpart 2, items A and B.

Subd. 14. **Financial responsibility.** "Financial responsibility" means the responsibility for billing CCBHC services rendered under contract by a designated collaborating organization.

Subd. 15. **Grievances.** CCBHCs and designated collaborating organization providers must allow all service recipients access to grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements including requirements that may be mandated by relevant accrediting entities.

Subd. 16. **Initial evaluation.** "Initial evaluation" means an evaluation that is designed to gather and document initial components of the comprehensive evaluation, allowing the assessor to formulate a preliminary diagnosis and the client to begin services.

Subd. 17. **Initial evaluation equivalents.** "Initial evaluation equivalents" means using a process that is approved by the commissioner as an alternative to the initial evaluation.

Subd. 18. **Integrated treatment plan.** "Integrated treatment plan" means a documented plan of care that uses the American Society for Addiction Medicine's six dimensions criteria as an organizational framework.

Subd. 19. **Limited English proficiency.** "Limited English proficiency" includes individuals who do not speak English as a primary language or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language assistance.

Subd. 20. **Outpatient withdrawal management.** "Outpatient withdrawal management" means a time-limited service delivered in an office setting, an outpatient behavioral health clinic, or a person's home by staff providing medically supervised evaluation and

detoxification services to achieve safe and comfortable withdrawal from substances and facilitate transition into ongoing treatment and recovery. Outpatient withdrawal management services include assessment, withdrawal management, planning, medication prescribing and management, trained observation of withdrawal symptoms, and supportive services.

Subd. 21. **Preliminary screening and risk assessment.** "Preliminary screening and risk assessment" means a screening and risk assessment that is completed at the first contact with the prospective CCBHC service recipient and determines the acuity of recipient need.

Subd. 22. **Preliminary treatment plan.** "Preliminary treatment plan" means an initial plan of care that is written as a part of all initial evaluations, initial evaluation equivalents, or comprehensive evaluations.

Subd. 23. **Needs assessment.** "Needs assessment" means a systematic approach to identifying community needs and determining program capacity to address the needs of the population being served.

Subd. 24. **Scope of services.** "Scope of services" means services that are published by the commissioner and that constitute a CCBHC encounter that is eligible for the daily bundled rate.

Subd. 25. **State-sanctioned crisis services.** "State-sanctioned crisis services" means adult and children's crisis response services conducted by an entity enrolled to provide crisis services under section 256B.0624.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. **[245.7353] APPLICABILITY.**

Subdivision 1. **Certification process.** (a) The commissioner must establish a state certification process for certified community behavioral health clinics that satisfy all federal and state requirements necessary for CCBHCs certified under sections 245.7351 to 245.736 to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner must consult with CCBHC stakeholders before establishing and implementing changes in the certification process and requirements.

(b) The certification process must:

(1) evaluate whether the prospective or recertifying CCBHC meets all certification requirements in this section;

(2) evaluate whether the prospective or recertifying CCBHC meets the certification requirements for all required services listed in section 245.7358; and

(3) include a review period that includes a site visit or virtual site visit conducted using two-way video conferencing technology within 90 calendar days of receipt of an application for certification or recertification.

Subd. 2. **Certifications and licensures required.** In addition to all other requirements contained in sections 245.7351 to 245.736, a CCBHC must:

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

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

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

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

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

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

(7) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926; and

(8) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8), as applicable when peer services are provided.

Subd. 3. **Certification schedule.** The commissioner must recertify CCBHCs no later than 36 months from the date of initial certification or the date of the last recertification. The commissioner must provide a 90-day notice in advance of recertification.

Subd. 4. **Variance authority.** When the standards listed in sections 245.7351 to 245.736 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 as described in subdivision 1 before granting variances under this subdivision. For the 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. 5. **Notice and opportunity for correction.** If the commissioner finds that a prospective or certified CCBHC has failed to comply with an applicable law or rule and this failure does not imminently endanger health, safety, or rights of the persons served by the program, the commissioner may issue a notice ordering a correction. The notice ordering a correction must state the following in plain language:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated; and

(3) the time allowed to correct each violation.

Subd. 6. **County letter of support.** A clinic that meets certification requirements for a CCBHC under sections 245.7351 to 245.736 is not subject to any state law or rule that requires a county contract or other form of county approval as a condition for licensure or enrollment as a medical assistance provider. The commissioner must require evidence from the CCBHC that it has an ongoing relationship with the county or counties it serves to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

Subd. 7. **Decertification, denial of certification, or recertification request.** (a) The commissioner must establish a process for decertification and must require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section.

(b) The commissioner must provide the following to providers for the certification, recertification, and decertification process:

(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.

Subd. 8. **Demonstration entities.** The commissioner may operate the demonstration program established by section 223 of the Protecting Access to Medicare Act if federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the

requirements of the demonstration program with the requirements under sections 245.7351 to 245.736 for CCBHCs receiving medical assistance reimbursement. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. **[245.7354] GOVERNANCE AND ORGANIZATIONAL STRUCTURE.**

Subdivision 1. **Eligible providers.** (a) An eligible CCBHC must be:

(1) a nonprofit organization, exempt from tax under section 501(c)(3) of the United States Internal Revenue Code;

(2) part of a local government behavioral health authority;

(3) operated under the authority of the Indian Health Service, an Indian Tribe, or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act; or

(4) an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act.

(b) A CCBHC must maintain documentation establishing its conformity with this section.

Subd. 2. **Collaboration with American Indian and Alaska Native entities.** (a) A CCBHC must enter into arrangements with the Indian Health Service and any Indian Tribes or Tribal or urban Indian organizations within their geographic service area to assist with and inform the provision of services for American Indian and Alaska Native clients.

(b) A CCBHC operated by the Indian Health Service, an Indian Tribe, or a Tribal or urban Indian organization is exempt from the requirement in paragraph (a).

Subd. 3. **Board members.** (a) CCBHC board members must be representative of the individuals being served by the CCBHC in terms of geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and types of disorders served. A CCBHC must incorporate meaningful participation by adult clients with mental illness, adults recovering from substance use disorders, and family members of CCBHC clients by:

(1) having a board that is comprised of at least 51 percent clients, people in recovery from behavioral health conditions, or their family members; or

(2) having a substantial portion of the governing board members meeting the criteria in clause (1) and implementing other specifically described methods for clients, people in recovery, and their family members to provide meaningful input to the board about the CCBHCs policies, processes, and services.

(b) A CCBHC must demonstrate to the commissioner how it meets the requirement in paragraph (a) or develop a transition plan with timelines appropriate to its governing board size and target population to meet this requirement.

(c) A CCBHC owned or operated by the state, a local government, a Tribal entity, or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership shall notify the commissioner, specify the reasons why the CCBHC cannot meet these requirements, and document that the CCBHC has developed or will develop an advisory structure and other specifically described methods for clients, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services.

(d) As an alternative to the board membership requirement in paragraph (a), a CCBHC may establish and implement other means of enhancing its governing body's ability to ensure that the CCBHC is responsive to the needs of its clients, families, and communities. Efforts to ensure responsiveness must focus on the full range of clients, services provided, geographic areas covered, types of disorders, and levels of care provided. A CCBHC must seek approval from the commissioner for any proposed alternative under this paragraph. If the commissioner rejects a proposed alternative, the commissioner must require that additional or different mechanisms be established to ensure that the board is responsive to the needs of CCBHC clients and families. Every CCBHC approved under this paragraph must make publicly available the changed outcomes and other results of the alternative means and structures employed under this paragraph.

(e) Members of a CCBHC's governing or advisory boards must also be representative of the communities in the CCBHC's service area and must be selected for expertise in health services, community affairs, local government, finance and banking, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one-half of the governing board members may derive more than 10 percent of their annual income from the health care industry.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. **[245.7355] MINIMUM STAFFING STANDARDS.**

Subdivision 1. **Generally.** (a) A CCBHC must meet minimum staffing requirements as identified in the certification process in the needs assessment under section 245.7357, subdivision 5.

(b) A CCBHC must employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals, licensed alcohol and drug counselors, staff who are culturally and linguistically trained to meet the needs of the population the clinic serves, and staff who are trained to make accommodations to meet the needs of clients with disabilities.

Subd. 2. **Management team requirements.** (a) The management team must include, at minimum, a chief executive officer or executive director and a medical director.

(b) The medical director does not need to be a full-time employee of the CCBHC.

(c) Depending on the size of the CCBHC, both positions may be held by the same person.

(d) The medical director must ensure the medical component of care and the integration of behavioral health, including addictions, and primary care are facilitated.

(e) The medical director must be a medically trained behavioral health care provider with appropriate education and licensure with prescription authority in psychopharmacology who can prescribe and manage medications independently.

Subd. 3. **Providers licensed to manage medication.** The CCBHC must directly employ or through formal arrangement utilize a medically trained behavioral health care provider who can independently prescribe and manage medications, including buprenorphine and other medications used to treat opioid and alcohol use disorders.

Subd. 4. **Alcohol and drug counselors.** A CCBHC must have staff, either directly employed or available through formal arrangements, who are credentialed substance use disorder specialists licensed under chapter 148F.

Subd. 5. **Peer services.** A CCBHC must have staff, either directly employed or available through formal arrangements, who are credentialed to provide peer support services under section 256B.0615, 256B.0616, or 245G.07, subdivision 2, clause (8).

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. **[245.7356] TRAINING REQUIREMENTS.**

Subdivision 1. **Training plan.** (a) A CCBHC must follow training plan requirements in existing statutes for specific certifications, licenses, providers, or service lines.

(b) A CCBHC must have a training plan, for all employed and contracted staff, and for providers at designated collaborating organizations who have contact with CCBHC clients.

Subd. 2. **Training requirements.** (a) A CCBHC must ensure that any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.

(b) At orientation and annually, a CCBHC must provide training about: (1) risk assessment, suicide prevention, and suicide response; and (2) the roles of families and peers.

(c) Credentialed personnel must comply with state licensing or certification requirements and other requirements issued by the commissioner in accordance with requirements under the Medicaid state plan.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. **[245.7357] ACCESSIBILITY AND AVAILABILITY OF SERVICES.**

Subdivision 1. **Accessibility and availability of services.** (a) A CCBHC must ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day.

(b) A CCBHC must provide a safe, functional, clean, and welcoming environment for clients and staff, conducive to the provision of services identified in program requirement.

(c) A CCBHC must provide outpatient clinical services during times that ensure accessibility and meet the needs of the client population to be served, including some nights and weekend hours.

(d) If a CCBHC serves individuals with limited English proficiency or with language-based disabilities, the CCBHC must take reasonable steps to provide meaningful access to services for those clients.

(e) A CCBHC must use culturally and linguistically appropriate screening tools and approaches that accommodate disabilities when appropriate.

(f) A CCBHC must ensure that interpretation and translation service are provided that are appropriate and timely for the size and needs of the limited-English-proficiency CCBHC client population. Any translation service providers must be trained to function in a medical and, preferably, a behavioral health setting.

(g) A CCBHC must ensure that documents or messages vital to a client's ability to access services, such as registration forms, sliding scale fee discount schedules, after-hours coverage, and signage are available for clients in languages common in the community served. A CCBHC must take into account literacy levels and the need for alternative formats for clients with disabilities. Such materials must be provided in a timely manner at intake. The requisite languages must be informed by the needs assessment prepared prior to certification and updated as necessary.

Subd. 2. **Sliding fee scales.** (a) A CCBHC must establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee to ensure that services to clients are not denied or limited due to an individual's inability to pay for services.

(b) The CCBHC must have written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. The policies under this subdivision must be applied equally to all individuals seeking services.

(c) The CCBHC must ensure that no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence or homelessness or lack of a permanent address.

Subd. 3. **Access accommodations.** (a) A CCBHC must have protocols addressing the needs of clients who do not live close to the CCBHC or within the CCBHC's geographic service area. A CCBHC must provide, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols under this subdivision must address management of an out-of-geographic-area individual's ongoing treatment needs beyond those required under this paragraph. The protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track clients seeking noncrisis services to the CCBHC or other clinic serving the client's county of residence. For distant clients within the CCBHC's geographic service area, CCBHCs shall consider the use of telehealth or telemedicine to the extent practicable. In no circumstances may any individual be refused services because of place of residence.

(b) To the extent possible, a CCBHC must provide transportation or transportation vouchers for clients.

(c) To the extent possible, a CCBHC must utilize mobile in-home, telehealth and telemedicine, and online treatment services to ensure clients have access to all required services.

(d) A CCBHC must engage in outreach and engagement activities to assist individuals and families to access benefits and formal or informal services to address behavioral health conditions and needs.

(e) Consistent with requirements of privacy, confidentiality, and client preference and need, a CCBHC must assist individuals and families of children and youth referred to external providers or resources in obtaining an appointment and must confirm the appointment was kept.

Subd. 4. **Addressing cultural needs.** A CCBHC must ensure all CCBHC services, including those supplied by its designated collaborating organizations, conform to the requirements of section 2402(a) of the Affordable Care Act; reflect person- and family-centered, recovery-oriented care; and are respectful of the individual's needs, preferences, and values. Person-centered and family-centered care includes care that recognizes the particular cultural and other needs of the individual. This includes but is not limited to services for clients who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC services. For clients who are AI/AN, these services may be provided either directly or by formal arrangement with Tribal providers.

Subd. 5. **Needs assessment.** As part of the process leading to certification, the commissioner must prepare an assessment of the needs of a prospective CCBHC's target client population and a staffing plan. The needs assessment must include cultural, linguistic, and treatment needs. The needs assessment must be performed prior to certification of a CCBHC in order to inform staffing and services. After certification, a CCBHC must update the needs assessment and the staffing plan, including both client and family and caregiver input. The needs assessment and staffing plan must be updated no less frequently than every three years.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. **[245.7358] REQUIRED SERVICES.**

Subdivision 1. **Generally.** CCBHCs must provide nine core services identified in subdivisions 2 and 3.

Subd. 2. **Required services to be provided directly.** Unless otherwise specified in sections 245.7351 to 245.736 and approved by the commissioner, a CCBHC must directly provide the following:

(1) ambulatory withdrawal management services ASAM levels 1.0 and 2.0;

(2) treatment planning;

(3) screening, assessment, diagnosis, and risk assessment;

(4) outpatient mental health treatment; and

(5) substance use disorder treatment services for both adult and adolescent populations.

Subd. 3. **Direct or contracted required services.** A CCBHC must provide the following services directly or via formal relationships with designated collaborating organizations:

(1) targeted case management;

(2) outpatient primary care screening and monitoring;

(3) community-based mental health care for veterans;

(4) peer, family support, and counselor services;

(5) psychiatric rehabilitation services; and

(6) crisis services conducted by a state-sanctioned provider.

Subd. 4. **Care coordination required.** A CCBHC must directly 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. Care coordination may be accomplished through partnerships or formal contracts with:

(1) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(2) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, Tribally licensed health care and mental health facilities, urban Indian health clinics, Department of

Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics.

Subd. 5. **Outreach and engagement required.** A CCBHC must provide outreach and engagement services to the community, including promoting accessibility and culturally and linguistically competent care, educating prospective CCBHC recipients about available services, and connecting prospective CCBHC recipients with needed services.

Subd. 6. **Initial evaluation; required elements.** (a) An initial evaluation must be completed by a mental health professional or clinical trainee and approved by a mental health professional as defined in section 245I.04, subdivision 2.

(b) The timing of initial evaluation administration must be determined based on results of the preliminary screening and risk assessment. If a client is assessed to be experiencing a crisis-level behavioral health need, care must be provided immediately or within three hours. If an urgent need is identified, the initial evaluation must be completed within one business day. For all other new clients, an initial evaluation is required within ten business days of the preliminary screening and risk assessment.

(c) Initial evaluation equivalents, as defined by the commissioner, may be completed to satisfy the requirement for the initial evaluation under this subdivision.

(d) The initial evaluation must include the following components:

(1) all data elements listed in section 245I.10, subdivision 5;

(2) the client's gender, ethnicity, and race;

(3) the client's insurance type and status and referral source;

(4) the client's primary and secondary language;

(5) the client's current housing status;

(6) for a client reporting substance use, an assessment of withdrawal potential;

(7) a list of current prescriptions and over-the-counter medications, as well as other substances the client may be taking;

(8) an assessment of whether the client is a risk to self or to others, including suicide risk factors;

(9) an assessment of whether the client has other concerns for their safety;

(10) an assessment of need for medical care with referral and follow-up as required;

(11) a determination of whether the client presently is or ever has been a member of the United States armed forces; and

(12) recommendations for services and preliminary treatment plan.

(e) For programs governed by sections 245.7351 to 245.736, the CCBHC initial evaluation requirements in this subdivision satisfy the requirements in:

(1) section 245I.10, subdivision 5;

(2) section 256B.0943, subdivisions 3 and 6, paragraph (b), clauses (1) and (2);

(3) section 256B.0623, subdivision 3, clause (4);

(4) section 245.4881, subdivisions 3 and 4;

(5) section 245.4711, subdivisions 3 and 4;

(6) Minnesota Rules, part 9520.0909, subpart 1;

(7) Minnesota Rules, part 9520.0910, subpart 1;

(8) Minnesota Rules, part 9520.0914, subpart 2, items A and B;

(9) Minnesota Rules, part 9520.0918, subparts 1 and 2; and

(10) Minnesota Rules, part 9520.0919, subparts 1 and 2.

Subd. 7. **Comprehensive evaluation; required elements.** (a) All new CCBHC clients must receive a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days following the preliminary screening and risk assessment.

(b) The comprehensive evaluation must be completed by a mental health professional or clinical trainee and approved by a mental health professional as defined in section 245I.04, subdivision 2.

(c) A comprehensive evaluation includes a review and synthesis of existing information obtained from external sources, including the use of an externally completed diagnostic assessment, internal staff, preliminary screening and risk assessment, crisis assessment, initial evaluation, primary care screenings, and other services received at the CCBHC.

(d) The assessor must complete a client's comprehensive evaluation within the client's cultural context.

(e) When a CCBHC client is engaged in substance use disorder services provided by the CCBHC, the comprehensive evaluation must also be approved by an alcohol and drug counselor as defined in section 245G.11, subdivision 5.

(f) A CCBHC comprehensive evaluation completed according to the standards in subdivision 7 replaces the requirements for a comprehensive assessment in section 245G.05, subdivision 1, if the following items are included in the comprehensive evaluation:

(1) chemical use history, including the amounts and types of chemicals, frequency and duration, periods of abstinence, and circumstances of relapse;

(2) for each chemical used within the previous 30 days, the date and time of most recent use and withdrawal potential;

(3) previous attempts at treatment for chemical use or gambling;

(4) problem behaviors when under the influence of chemicals; and

(5) legal interventions and arrests.

(g) The comprehensive evaluation must include the following components:

(1) all data elements listed in section 245I.10, subdivision 6;

(2) the client's gender, ethnicity, and race;

(3) the client's insurance status and type and referral source;

(4) the client's primary and secondary language;

(5) a determination of whether the client presently is or ever has been a member of the United States armed forces;

(6) if an initial evaluation was completed, an update on each component;

(7) for a client who reports substance use, an assessment of withdrawal potential;

(8) an assessment of need for medical care and follow-up as required;

(9) any drug allergies;

(10) the client's legal issues;

(11) the client's parenting status; and

(12) any data obtained from administration of an approved depression screening tool.

(h) A comprehensive evaluation must be updated at least annually for all adult clients who continue to engage in behavioral health services, and:

(1) when the client's presentation does not appear to align with the current diagnostic formulation; or

(2) when the client or mental health professional suspect the emergence of a new diagnosis.

(i) A comprehensive evaluation update must contain the following components:

(1) a written update detailing all significant new or changed mental health symptoms, as well as a description of how the new or changed symptoms are impacting functioning;

(2) any diagnostic formulation updates, including rationale for new diagnoses as needed; and

(3) a rationale for removal of any existing diagnoses, as needed.

(j) When completing a comprehensive evaluation of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three. The comprehensive evaluation of children age five years and younger:

(1) must include an initial session without the client present and may include treatment to the parents or guardians along with inquiring about the child;

(2) may consist of three to five separate encounters;

(3) must incorporate the level of care assessment;

(4) must be completed prior to recommending additional CCBHC services; and

(5) must not contain scoring of the American Society of Addiction Medicine six dimensions.

(k) For programs governed by sections 245.7351 to 245.736, the CCBHC initial evaluation requirements in this subdivision satisfy the requirements in:

(1) section 245I.10, subdivision 2a;

(2) section 245I.10, subdivisions 4 to 6;

(3) section 245G.04, subdivision 1;

(4) section 256B.0943, subdivisions 3 and 6, paragraph (b), clause (1);

(5) section 256B.0623, subdivision 3, clause (4);

(6) section 245.4711, subdivision 2;

(7) section 245.4881, subdivision 2;

(8) Minnesota Rules, part 9520.0910, subpart 1;

(9) Minnesota Rules, part 9520.0909, subpart 1; and

(10) Minnesota Rules, part 9520.0914, subpart 2, items A and B.

Subd. 8. **Integrated treatment plan; required elements.** (a) An integrated treatment plan must be approved by a mental health professional as defined in section 245I.04, subdivision 2.

(b) An integrated treatment plan must be completed within 60 calendar days following the completion of the preliminary screening and risk assessment.

(c) An integrated treatment plan must use the American Society of Addiction Medicine six-dimensional framework; be structured as defined in section 245I.10, subdivisions 7 and 8; and use a person- and family-centered planning process that includes the client, any family or client-identified natural supports, CCBHC service providers, and care coordination staff.

(d) An integrated treatment plan must be updated at least every six months or earlier based on changes in the client's circumstances.

(e) When a client is engaged in substance use disorder services at a CCBHC, the integrated treatment plan must also be approved by an alcohol and drug counselor as defined in section 245G.11, subdivision 5.

(f) The treatment plan must integrate prevention, medical and behavioral health needs, and service delivery and must be developed by the CCBHC in collaboration with and endorsed by the client, the adult client's family to the extent the client wishes, or family or caregivers of youth and children. The treatment plan must also be coordinated with staff or programs necessary to carry out the plan.

(g) The CCBHC integrated treatment plan requirements in this subdivision replaces the requirements in sections:

(1) 256B.0943, subdivision 6, paragraph (b), clause (2);

(2) 245I.10, subdivisions 7 and 8;

(3) 245G.06, subdivision 1; and

(4) 245G.09, subdivision 3, clause (6).

Subd. 9. **Exemptions to evaluation and treatment planning requirements.** (a) In situations where a CCBHC client is receiving exclusively psychiatric evaluation and

management services and no other CCBHC services, the psychiatric history and physical fulfills requirements for the comprehensive evaluation, and a separate comprehensive evaluation is not required.

(b) Each new client must have a preliminary screening and risk assessment.

(c) Evaluation and management documentation and treatment goals fulfill requirements for the CCBHC integrated treatment plan.

(d) Comprehensive evaluation updates and integrated treatment plan updates are not required for clients receiving exclusively psychiatric evaluation and management services.

(e) If the client is subsequently referred to any other CCBHC service, a comprehensive evaluation and integrated treatment plan must be completed within 60 calendar days of the referral, and the client must have comprehensive evaluation and integrated treatment plan updates as defined in subdivisions 7 and 8.

(f) Clients receiving exclusively psychiatric evaluation and management services must be provided with information about the full array of services available to them within the CCBHC at the first appointment for new clients and next scheduled appointment for existing clients. This can be accomplished via face-to-face meeting with a care coordinator or incorporated into a scheduled meeting with the psychiatric provider. The provider must document client receipt of this information within the client's electronic health record.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. **[245.7359] REQUIRED EVIDENCE-BASED SERVICES.**

Subdivision 1. **Generally.** A CCBHC must use evidence-based practices in all services. Treatments must be provided in a manner appropriate for each client's phase of life and development, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. Specifically, when treating children and adolescents, a CCHBC must provide evidence-based services that are developmentally appropriate, youth guided, and family and caregiver driven. When treating older adults, an individual client's desires and functioning must be considered, and appropriate evidence-based treatments must be provided. When treating individuals with developmental or other cognitive disabilities, level of functioning must be considered, and appropriate evidence-based treatments must be provided.

The treatments referenced in this subdivision must be delivered by staff with specific training in treating the segment of the population being served.

Subd. 2. **Required evidence-based practices.** A CCBHC must use evidence-based practices, including the use of cognitive behavioral therapy, motivational interviewing, stages of change, and trauma treatment appropriate for populations being served.

Subd. 3. **Issuance of and amendments to evidence-based practices requirements.** 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. The commissioner must take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner must provide stakeholders with an opportunity to comment.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. **[245.736] DESIGNATED COLLABORATING ORGANIZATION.**

Subdivision 1. **Generally.** A CCBHC must directly provide a core set of services listed in section 245.7358, subdivision 2, and may directly provide or contract for the remainder of the services listed in section 245.7358, subdivision 3, with a designated collaborating organization as defined in section 245.7351, subdivision 10, that has the required authority to provide that service and that meets the criteria as a designated collaborating organization under subdivision 2.

Subd. 2. **Designated collaborating organization requirements.** (a) A CCBHC providing CCBHC services via a designated collaborating organization agreement must:

(1) have a formal agreement, as defined in section 245.7351, subdivision 11, with the designated collaborating organization to furnish one or more of the allowable services listed under section 245.7358, subdivision 3;

(2) ensure that CCBHC services provided by a designated collaborating organization must be provided in accordance with CCBHC service standards and provider requirements;

(3) maintain responsibility for coordinating care and clinical and financial responsibility for the services provided by a designated collaborating organization;

(4) as applicable and necessary, ensure that a contracted designated collaborating organization participates in CCBHC care coordination activities, including utilizing health information technology to facilitate coordination and care transfers across organizations and arranging access to data necessary for quality and financial operations and reporting;

(5) ensure beneficiaries receiving CCBHC services at the designated collaborating organization have access to the CCBHC grievance process;

(6) submit all designated collaborating organization agreements for review and approval by the commissioner prior to the designated collaborating organization furnishing CCBHC services; and

(7) meet any additional requirements issued by the commissioner.

(b) Designated collaborating organization agreements must be submitted during the certification process. Adding new designated collaborating organization relationships after initial certification requires updates to the CCBHC certification. A CCBHC must update designated collaborating organization information and the designated collaborating organization agreement with the commissioner a minimum of 30 days prior to the execution of a designated collaborating organization agreement. The commissioner must review and approve or offer recommendations for designated collaborating organization agreement modifications

(c) Designated collaborating organizations furnishing services under an agreement with CCBHCs must meet all standards established in sections 245.7351 to 245.736 for the service the designated collaborating organization is providing. CCBHCs maintain responsibility for care coordination and are clinically and financially responsible for CCBHC services provided by a designated collaborating organization.

(d) Designated collaborating organization financial and payment processes must follow those outlined in section 256B.0625, subdivision 5m, paragraph (c), clause (10).

Subd. 3. **Designated collaborative organization agreements.** Designated collaborative organization agreements must include:

(1) the scope of CCBHC services to be furnished;

(2) the payment methodology and rates for purchased services;

(3) a requirement that the CCBHC maintains financial and clinical responsibility for services provided by the designated collaborating organization;

(4) a requirement that the CCBHC retains responsibility for care coordination;

(5) a requirement that the designated collaborating organization must have the necessary certifications, licenses, and enrollments to provide the services;

(6) a requirement that the staff providing CCBHC services within the designated collaborating organization must have the proper licensure for the services provided;

(7) a requirement that the designated collaborating organization meets CCBHC cultural competency and training requirements;

(8) a requirement that the designated collaborating organization must follow all federal, state, and CCBHC requirements for confidentiality and data privacy;

(9) a requirement that the designated collaborating organization must follow the grievance procedures of the CCBHC;

(10) a requirement that the designated collaborating organization must follow the CCBHC requirements for person- and family-centered, recovery-oriented care, being respectful of the individual person's needs, preferences, and values, and ensuring involvement by the person being served and self-direction of services received. Services for children and youth must be family-centered, youth-guided, and developmentally appropriate;

(11) a requirement that clients seeking services must have freedom of choice of providers;

(12) a requirement that the designated collaborating organization must be part of the CCBHCs health information technology system directly or through data integration;

(13) a requirement that the designated collaborating organization must provide all clinical and financial data necessary to support CCBHC required service and billing operations; and

(14) a requirement that the CCBHC and the designated collaborating organization have safeguards in place to ensure that the designated collaborating organization does not receive a duplicate payment for services that are included in the CCBHC's daily bundled rate.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2022, section 245A.02, subdivision 2c, is amended to read:

Subd. 2c. **Annual or annually; family child care ~~training requirements~~.** For the purposes of sections 245A.50 to 245A.53, "annual" or "annually" means ~~the 12-month period beginning on the license effective date or the annual anniversary of the effective date~~

~~and ending on the day prior to the annual anniversary of the license effective date~~ each calendar year.

Sec. 13. Minnesota Statutes 2022, section 245A.04, subdivision 1, is amended to read:

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

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the required information.

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

(b) An application for licensure must identify all controlling individuals as defined in section 245A.02, subdivision 5a, and must designate one individual to be the authorized agent. The application must be signed by the authorized agent and must include the authorized agent's first, middle, and last name; mailing address; and email address. By submitting an application for licensure, the authorized agent consents to electronic communication with the commissioner throughout the application process. The authorized agent must be authorized to accept service on behalf of all of the controlling individuals. A government

entity that holds multiple licenses under this chapter may designate one authorized agent for all licenses issued under this chapter or may designate a different authorized agent for each license. Service on the authorized agent is service on all of the controlling individuals. It is not a defense to any action arising under this chapter that service was not made on each controlling individual. The designation of a controlling individual as the authorized agent under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

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

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

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

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

(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, if any;

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

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

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

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

(1) the applicant's taxpayer identification numbers including the Minnesota tax 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 inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

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

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

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

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

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

Sec. 14. Minnesota Statutes 2022, section 245A.04, subdivision 7, is amended to read:

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

(1) the name of the license holder;

(2) the address of the program;

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

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

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

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

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

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

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

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

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

(2) been denied a license under this chapter, within the past two years;

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

~~(4) an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent; or~~

~~(5)~~ (4) failed to submit the information required of an applicant under subdivision 1, paragraph (f) or (g), after being requested by the commissioner.

When a license issued under this chapter is revoked ~~under clause (1) or (3)~~, the license holder and each affiliated controlling individual with a revoked license may not hold any license under chapter 245A for five years following the revocation, and other licenses held by the applicant~~,~~ or license holder~~,~~ or licenses affiliated with each controlling individual shall also be revoked.

(e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license affiliated with a license holder or controlling individual that had a license revoked within the past five years if the commissioner determines that (1) the license holder or controlling individual is operating the program in substantial compliance with applicable laws and rules, and (2) the program's continued operation is in the best interests of the community being served.

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

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

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

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

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

~~(h)~~ (k) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

~~(i)~~ (l) 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 apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

~~(j)~~ (m) 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.

Sec. 15. Minnesota Statutes 2022, section 245A.04, subdivision 7a, is amended to read:

Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change that would alter the license information listed under subdivision 7, paragraph (a).

(b) A license holder must also notify the commissioner, in a manner prescribed by the commissioner, before making any change:

(1) to the license holder's authorized agent as defined in section 245A.02, subdivision 3b;

(2) to the license holder's controlling individual as defined in section 245A.02, subdivision 5a;

(3) to the license holder information on file with the secretary of state;

(4) in the location of the program or service licensed under this chapter; and

(5) to the federal or state tax identification number associated with the license holder.

(c) When, for reasons beyond the license holder's control, a license holder cannot provide the commissioner with prior notice of the changes in paragraph (b), clauses (1) to (3), the license holder must notify the commissioner by the tenth business day after the change and must provide any additional information requested by the commissioner.

(d) When a license holder notifies the commissioner of a change to the license holder information on file with the secretary of state, the license holder must provide amended articles of incorporation and other documentation of the change.

(e) Upon implementation of the provider licensing and reporting hub, license holders must enter and update information in the hub in a manner prescribed by the commissioner.

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

Sec. 16. Minnesota Statutes 2022, 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;

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

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

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

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

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

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

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules, including but not limited to this chapter and chapters 119B and 245C;

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

(11) for a family foster setting, has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the individual's ability to safely provide care to foster children.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. When an order is issued through the hub, the applicant or license holder is deemed to have received the order upon the date of issuance through the hub. The applicant may appeal the denial by notifying the commissioner in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service or through the hub, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

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

Sec. 17. Minnesota Statutes 2022, section 245A.055, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of closure.** If a license is closed, the commissioner must notify the license holder of closure by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the notice of closure must be mailed to the last known address of the license holder and must inform the license holder why the license was closed and that the license holder has the right to request reconsideration of the closure. If the license holder believes that the license was closed in error, the license holder may ask the commissioner to reconsider the closure. The license holder's request for reconsideration must be made in writing and must include documentation that the licensed program has served a client in the previous 12 months. The request for reconsideration must be postmarked and sent to the commissioner or submitted through the provider licensing and reporting hub within 20 calendar days after the license holder receives the notice of closure. Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration. If the order is issued through the provider hub, the reconsideration must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. A timely request for reconsideration stays

imposition of the license closure until the commissioner issues a decision on the request for reconsideration.

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

Sec. 18. Minnesota Statutes 2022, section 245A.06, subdivision 1, is amended to read:

Subdivision 1. **Contents of correction orders and conditional licenses.** (a) If the commissioner finds that the applicant or license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a correction order and an order of conditional license to the applicant or license holder. When issuing a conditional license, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program. The correction order or conditional license must state the following in plain language:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated;

(3) the time allowed to correct each violation; and

(4) if a license is made conditional, the length and terms of the conditional license, and the reasons for making the license conditional.

(b) Nothing in this section prohibits the commissioner from proposing a sanction as specified in section 245A.07, prior to issuing a correction order or conditional license.

(c) The commissioner may issue a correction order and an order of conditional license to the applicant or license holder through the provider licensing and reporting hub. When an order is issued through the hub, the applicant or license holder is deemed to have received the order upon the date of issuance through the hub.

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

Sec. 19. Minnesota Statutes 2022, section 245A.06, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the Department of Human Services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be made in writing and must be postmarked and sent to the commissioner or submitted in the provider

licensing and reporting hub within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

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

(2) explain why they are in error; and

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2022, section 245A.06, subdivision 4, is amended to read:

Subd. 4. **Notice of conditional license; reconsideration of conditional license.** (a) If a license is made conditional, the license holder must be notified of the order by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the conditional license was ordered and must inform the license holder of the right to request reconsideration of the conditional license by the commissioner. The license holder may request reconsideration of the order of conditional license by notifying the commissioner by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within ten calendar days after the license holder received the order. If a request is made by personal

service or through the hub, it must be received by the commissioner within ten calendar days after the license holder received the order. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. A timely request for reconsideration shall stay imposition of the terms of the conditional license until the commissioner issues a decision on the request for reconsideration. If the commissioner issues a dual order of conditional license under this section and an order to pay a fine under section 245A.07, subdivision 3, the license holder has a right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The scope of the contested case hearing shall include the fine and the conditional license. In this case, a reconsideration of the conditional license will not be conducted under this section. If the license holder does not appeal the fine, the license holder does not have a right to a contested case hearing and a reconsideration of the conditional license must be conducted under this subdivision.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

Sec. 21. Minnesota Statutes 2022, section 245A.07, is amended by adding a subdivision to read:

Subd. 2b. **Immediate suspension of residential programs.** For suspensions issued to a licensed residential program as defined in section 245A.02, subdivision 14, the effective date of the order may be delayed for up to 30 calendar days to provide for the continuity of care of service recipients. The license holder must cooperate with the commissioner to ensure service recipients receive continued care during the period of the delay and to facilitate the transition of service recipients to new providers. In these cases, the suspension order takes effect when all service recipients have been transitioned to a new provider or 30 days after the suspension order was issued, whichever comes first.

Sec. 22. Minnesota Statutes 2022, section 245A.07, is amended by adding a subdivision to read:

Subd. 2c. **Immediate suspension for programs with multiple licensed service sites.** (a) For license holders that operate more than one service site under a single license, the suspension order must be specific to the service site or sites where the commissioner determines an order is required under subdivision 2. The order must not apply to other

service sites operated by the same license holder unless the commissioner has included in the order an articulable basis for applying the order to other service sites.

(b) If the commissioner has issued more than one license to the license holder under this chapter, the suspension imposed under this section must be specific to the license for the program at which the commissioner determines an order is required under subdivision 2. The order must not apply to other licenses held by the same license holder if those programs are being operated in substantial compliance with applicable law and rules.

Sec. 23. Minnesota Statutes 2022, 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;

(4) a license holder is excluded from any program administered by the commissioner under section 245.095; or

(5) revocation is required under section 245A.04, subdivision 7, paragraph (d).

A license holder who has had a license issued under this chapter suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state in plain language the reasons the license was suspended or revoked, or a fine was ordered. When an order is issued through the hub, the applicant or license holder is deemed to have received the order upon the date of issuance through the hub.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts

1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service or through the hub, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (f) and (g), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service or through the hub, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

(i) the license holder shall forfeit $1,000 for each determination of maltreatment of a child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

(ii) if the commissioner determines that a determination of maltreatment for which the license holder is responsible is the result of maltreatment that meets the definition of serious maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit $5,000;

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

(iv) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(v) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iv).

For purposes of this section, "occurrence" means each violation identified in the 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.

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

Sec. 24. Minnesota Statutes 2022, section 245A.10, subdivision 6, is amended to read:

Subd. 6. **License not issued until license or certification fee is paid.** The commissioner shall not issue or reissue a license or certification until the license or certification fee is paid. The commissioner shall send a bill for the license or certification fee to the billing address identified by the license holder. If the license holder does not submit the license or certification fee payment by the due date, the commissioner shall send the license holder a past due notice. If the license holder fails to pay the license or certification fee by the due date on the past due notice, the commissioner shall send a final notice to the license holder informing the license holder that the program license will expire on December 31 unless the license fee is paid before December 31. If a license expires, the program is no longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2, must not operate after the expiration date. After a license expires, if the former license holder wishes to provide licensed services, the former license holder must submit a new license application and application fee under subdivision 3.

Sec. 25. Minnesota Statutes 2022, section 245A.10, is amended by adding a subdivision to read:

Subd. 9. **License not reissued until outstanding debt is paid.** The commissioner shall not reissue a license or certification until the license holder has paid all outstanding debts related to a licensing fine or settlement agreement for which payment is delinquent. If the payment is past due, the commissioner shall send a past due notice informing the license holder that the program license will expire on December 31 unless the outstanding debt is paid before December 31. If a license expires, the program is no longer licensed and must not operate after the expiration date. After a license expires, if the former license holder wishes to provide licensed services, the former license holder must submit a new license application and application fee under subdivision 3.

Sec. 26. Minnesota Statutes 2022, section 245A.16, is amended by adding a subdivision to read:

Subd. 10. **Licensing and reporting hub.** Upon implementation of the provider licensing and reporting hub, county staff who perform licensing functions must use the hub in the manner prescribed by the commissioner.

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

Sec. 27. Minnesota Statutes 2022, section 245A.50, subdivision 3, is amended to read:

Subd. 3. **First aid.** (a) Before initial licensure and before caring for a child, license holders, second adult caregivers, and substitutes must be trained in pediatric first aid. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training include individuals approved as first aid instructors. License holders, second adult caregivers, and substitutes must repeat pediatric first aid training every two years. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~ License holders, second adult caregivers, and substitutes must not let the training expire.

(b) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.

Sec. 28. Minnesota Statutes 2022, section 245A.50, subdivision 4, is amended to read:

Subd. 4. **Cardiopulmonary resuscitation.** (a) Before initial licensure and before caring for a child, license holders, second adult caregivers, and substitutes must be trained in pediatric cardiopulmonary resuscitation (CPR), including CPR techniques for infants and children, and in the treatment of obstructed airways. The CPR training must have been provided by an individual approved to provide CPR instruction. License holders, second adult caregivers, and substitutes must repeat pediatric CPR training at least once every two years and must document the training in the license holder's records. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~ License holders, second adult caregivers, and substitutes must not let the training expire.

(b) Persons providing CPR training must use CPR training that has been developed:

(1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or

(2) using nationally recognized, evidence-based guidelines for CPR training and incorporates psychomotor skills to support the instruction.

Sec. 29. Minnesota Statutes 2022, section 245A.50, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) License holders must ensure and document that before the license holder, second adult caregivers, substitutes, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death. In addition, license holders must ensure and document that before the license holder, second adult caregivers, substitutes, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

(b) Sudden unexpected infant death reduction training required under this subdivision must, at a minimum, address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Abusive head trauma training required under this subdivision must, at a minimum, address the risk factors related to shaking infants and young children, means of reducing the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

(d) Training for family and group family child care providers must be developed by the commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved by the Minnesota Center for Professional Development. Sudden unexpected infant death reduction training and abusive head trauma training may be provided in a single course of no more than two hours in length.

(e) Sudden unexpected infant death reduction training and abusive head trauma training required under this subdivision must be completed in person or as allowed under subdivision 10, clause (1) or (2), at least once every two years. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~ On the years when the individual receiving training is not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the individual receiving training in accordance with this subdivision must receive sudden unexpected infant death reduction

training and abusive head trauma training through a video of no more than one hour in length. The video must be developed or approved by the commissioner.

(f) An individual who is related to the license holder as defined in section 245A.02, subdivision 13, and who is involved only in the care of the license holder's own infant or child under school age and who is not designated to be a second adult caregiver, helper, or substitute for the licensed program, is exempt from the sudden unexpected infant death and abusive head trauma training.

Sec. 30. Minnesota Statutes 2022, section 245A.50, subdivision 6, is amended to read:

Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

(b) Family and group family child care programs licensed by the Department of Human Services that serve a child or children under eight years of age must document training that fulfills the requirements in this subdivision.

(1) Before a license holder, second adult caregiver, substitute, or helper transports a child or children under age eight in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this subdivision may be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

(2) Training required under this subdivision must be at least one hour in length, completed at initial training, and repeated at least once every five years. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~ At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(3) Training under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(c) Child care providers that only transport school-age children as defined in section 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

Sec. 31. Minnesota Statutes 2022, section 245A.50, subdivision 9, is amended to read:

Subd. 9. **Supervising for safety; training requirement.** (a) Courses required by this subdivision must include the following health and safety topics:

(1) preventing and controlling infectious diseases;

(2) administering medication;

(3) preventing and responding to allergies;

(4) ensuring building and physical premises safety;

(5) handling and storing biological contaminants;

(6) preventing and reporting child abuse and maltreatment; and

(7) emergency preparedness.

(b) Before initial licensure and before caring for a child, all family child care license holders and each second adult caregiver shall complete and document the completion of the six-hour Supervising for Safety for Family Child Care course developed by the commissioner.

(c) The license holder must ensure and document that, before caring for a child, all substitutes have completed the four-hour Basics of Licensed Family Child Care for Substitutes course developed by the commissioner, which must include health and safety topics as well as child development and learning.

(d) The family child care license holder and each second adult caregiver shall complete and document:

(1) the annual completion of either:

(i) a two-hour active supervision course developed by the commissioner; or

(ii) any courses in the ensuring safety competency area under the health, safety, and nutrition standard of the Knowledge and Competency Framework that the commissioner has identified as an active supervision training course; and

(2) the completion at least once every five years of the two-hour courses Health and Safety I and Health and Safety II. ~~When the training is due for the first time or expires, it~~

~~must be taken no later than the day before the anniversary of the license holder's license effective date.~~ A license holder's or second adult caregiver's completion of either training in a given year meets the annual active supervision training requirement in clause (1).

(e) At least once every three years, license holders must ensure and document that substitutes have completed the four-hour Basics of Licensed Family Child Care for Substitutes course. ~~When the training expires, it must be retaken no later than the day before the anniversary of the license holder's license effective date.~~

Sec. 32. Minnesota Statutes 2022, section 245H.01, subdivision 3, is amended to read:

Subd. 3. **Center operator or program operator.** "Center operator" or "program operator" means the person exercising supervision or control over the center's or program's operations, planning, and functioning. ~~There may be more than one designated center operator or program operator.~~

Sec. 33. Minnesota Statutes 2022, section 245H.01, is amended by adding a subdivision to read:

Subd. 4a. **Certification holder contact person.** "Certification holder contact person" means an individual designated by the organization who:

(1) oversees all center operators for the organization;

(2) acts as the authorized agent for background studies required in section 245H.10; and

(3) is authorized to be the designated contact person for communicating with the commissioner regarding all items pursuant to chapter 245H.

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

Sec. 34. Minnesota Statutes 2022, section 245H.03, subdivision 2, is amended to read:

Subd. 2. **Application submission.** The commissioner shall provide application instructions and information about the rules and requirements of other state agencies that affect the applicant. The certification application must be submitted in a manner prescribed by the commissioner. Upon implementation of the provider licensing and reporting hub, applicants must use the hub in the manner prescribed by the commissioner. The commissioner shall act on the application within 90 working days of receiving a completed application.

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

Sec. 35. Minnesota Statutes 2022, section 245H.03, subdivision 3, is amended to read:

Subd. 3. **Incomplete applications.** When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the documents submitted do not meet certification requirements, the commissioner shall provide the applicant written notice that the application is incomplete or deficient. In the notice, the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is complete. An applicant's failure to submit a complete application after receiving notice from the commissioner is basis for certification denial. For purposes of this section, when a denial order is issued through the provider licensing and reporting hub, the applicant is deemed to have received the order upon the date of issuance through the hub.

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

Sec. 36. Minnesota Statutes 2022, section 245H.03, subdivision 4, is amended to read:

Subd. 4. **Reconsideration of certification denial.** (a) The applicant may request reconsideration of the denial by notifying the commissioner by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the order. If a request is made by personal service or through the hub, it must be received by the commissioner within 20 calendar days after the applicant received the order. The applicant may submit with the request for reconsideration a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

Sec. 37. Minnesota Statutes 2022, section 245H.06, subdivision 1, is amended to read:

Subdivision 1. **Correction order requirements.** (a) If the applicant or certification holder failed to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

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

(2) the specific law or rule violated; and

(3) the time allowed to correct each violation.

(b) The commissioner may issue a correction order to the applicant or certification holder through the provider licensing and reporting hub. When an order is issued through the hub, the applicant or certification is deemed to have received the order upon the date of issuance through the hub.

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

Sec. 38. Minnesota Statutes 2022, section 245H.06, subdivision 2, is amended to read:

Subd. 2. **Reconsideration request.** (a) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the part of the correction order that is allegedly erroneous. A request for reconsideration must be made in writing~~,~~ and postmarked~~,~~ or submitted through the provider licensing and reporting hub, and sent to the commissioner within 20 calendar days after the applicant or certification holder received the correction order, and must:

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

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

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

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

(c) Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration.

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

Sec. 39. Minnesota Statutes 2022, section 245H.07, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) The commissioner may decertify a center if a certification holder:

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

(2) knowingly withheld relevant information from or gave false or misleading information to the commissioner in connection with an application for certification, in connection with

the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; or

(3) has authorization to receive child care assistance payments revoked pursuant to chapter 119B.

(b) When considering decertification, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule.

(c) When a center is decertified, the center is ineligible to receive a child care assistance payment under chapter 119B.

(d) The commissioner may issue a decertification order to a certification holder through the provider licensing and reporting hub. When an order is issued through the hub, the certification holder is deemed to have received the order upon the date of issuance through the hub.

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

Sec. 40. Minnesota Statutes 2022, section 245H.07, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of decertification.** (a) The certification holder may request reconsideration of the decertification by notifying the commissioner by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. The request must be made in writing. If sent by certified mail, the request must be postmarked and sent to the commissioner within 20 calendar days after the certification holder received the order. If a request is made by personal service or through the hub, it must be received by the commissioner within 20 calendar days after the certification holder received the order. With the request for reconsideration, the certification holder may submit a written argument or evidence in support of the request for reconsideration.

(b) The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

Sec. 41. Minnesota Statutes 2022, section 245I.20, subdivision 10, is amended to read:

Subd. 10. **Application procedures.** (a) The applicant for certification must submit any documents that the commissioner requires on forms approved by the commissioner. Upon implementation of the provider licensing and reporting hub, applicants must use the hub in the manner prescribed by the commissioner.

(b) Upon submitting an application for certification, an applicant must pay the application fee required by section 245A.10, subdivision 3.

(c) The commissioner must act on an application within 90 working days of receiving a completed application.

(d) When the commissioner receives an application for initial certification that is incomplete because the applicant failed to submit required documents or is deficient because the submitted documents do not meet certification requirements, the commissioner must provide the applicant with written notice that the application is incomplete or deficient. In the notice, the commissioner must identify the particular documents that are missing or deficient and give the applicant 45 days to submit a second application that is complete. An applicant's failure to submit a complete application within 45 days after receiving notice from the commissioner is a basis for certification denial.

(e) The commissioner must give notice of a denial to an applicant when the commissioner has made the decision to deny the certification application. In the notice of denial, the commissioner must state the reasons for the denial in plain language. The commissioner must send or deliver the notice of denial to an applicant by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. When an order is issued through the hub, the applicant is deemed to have received the order upon the date of issuance through the hub. In the notice of denial, the commissioner must state the reasons that the commissioner denied the application and must inform the applicant of the applicant's right to request a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an applicant delivers an appeal by personal service or through the hub, the commissioner must receive the appeal within 20 calendar days after the applicant received the notice of denial.

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

Sec. 42. Minnesota Statutes 2022, section 245I.20, subdivision 13, is amended to read:

Subd. 13. **Correction orders.** (a) If the applicant or certification holder fails to comply with a law or rule, the commissioner may issue a correction order. The correction order must state:

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

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

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

(b) If the applicant or certification holder believes that the commissioner's correction order is erroneous, the applicant or certification holder may ask the commissioner to reconsider the part of the correction order that is allegedly erroneous. An applicant or certification holder must make a request for reconsideration in writing. The request must be postmarked and sent to the commissioner or submitted in the provider licensing and reporting hub within 20 calendar days after the applicant or certification holder received the correction order; and the request must:

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

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

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

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

(d) If the commissioner finds that the applicant or certification holder failed to correct the violation specified in the correction order, the commissioner may decertify the certified mental health clinic according to subdivision 14.

(e) Nothing in this subdivision prohibits the commissioner from decertifying a mental health clinic according to subdivision 14.

(f) The commissioner may issue a correction order to the applicant or certification holder through the provider licensing and reporting hub. When an order is issued through the hub, the applicant or certification holder is deemed to have received the order upon the date of issuance through the hub.

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

Sec. 43. Minnesota Statutes 2022, section 245I.20, subdivision 14, is amended to read:

Subd. 14. **Decertification.** (a) The commissioner may decertify a mental health clinic if a certification holder:

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

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

(b) When considering decertification of a mental health clinic, the commissioner must consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of clients.

(c) If the commissioner decertifies a mental health clinic, the order of decertification must inform the certification holder of the right to have a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The commissioner may issue the order through the provider licensing and reporting hub. When an order is issued through the hub, the certification holder is deemed to have received the order upon the date of issuance through the hub. The certification holder may appeal the decertification. The certification holder must appeal a decertification in writing and send or deliver the appeal to the commissioner by certified mail ~~or~~, by personal service, or through the provider licensing and reporting hub. If the certification holder mails the appeal, the appeal must be postmarked and sent to the commissioner within ten calendar days after the certification holder receives the order of decertification. If the certification holder delivers an appeal by personal service or through the hub, the commissioner must receive the appeal within ten calendar days after the certification holder received the order. If a certification holder submits a timely appeal of an order of decertification, the certification holder may continue to operate the program until the commissioner issues a final order on the decertification.

(d) If the commissioner decertifies a mental health clinic pursuant to paragraph (a), clause (1), based on a determination that the mental health clinic was responsible for maltreatment, and if the certification holder appeals the decertification according to paragraph (c), and appeals the maltreatment determination under section 260E.33, the final decertification determination is stayed until the commissioner issues a final decision regarding the maltreatment appeal.

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

Sec. 44. Minnesota Statutes 2022, section 245I.20, subdivision 16, is amended to read:

Subd. 16. **Notifications required and noncompliance.** (a) A certification holder must notify the commissioner, in a manner prescribed by the commissioner, and obtain the commissioner's approval before making any change to the name of the certification holder or the location of the mental health clinic. Upon implementation of the provider licensing

and reporting hub, certification holders must enter and update information in the hub in a manner prescribed by the commissioner.

(b) Changes in mental health clinic organization, staffing, treatment, or quality assurance procedures that affect the ability of the certification holder to comply with the minimum standards of this section must be reported in writing by the certification holder to the commissioner within 15 days of the occurrence. Review of the change must be conducted by the commissioner. A certification holder with changes resulting in noncompliance in minimum standards must receive written notice and may have up to 180 days to correct the areas of noncompliance before being decertified. Interim procedures to resolve the noncompliance on a temporary basis must be developed and submitted in writing to the commissioner for approval within 30 days of the commissioner's determination of the noncompliance. Not reporting an occurrence of a change that results in noncompliance within 15 days, failure to develop an approved interim procedure within 30 days of the determination of the noncompliance, or nonresolution of the noncompliance within 180 days will result in immediate decertification.

(c) The mental health clinic may be required to submit written information to the department to document that the mental health clinic has maintained compliance with this section and mental health clinic procedures.

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

Sec. 45. Minnesota Statutes 2022, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of ~~section 245.735, subdivision 3~~ sections 245.7351 to 245.736.

(b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245.7358; and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph (a), clause (6)~~ 245.7358, is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly certified CCBHCs under ~~section 245.735, subdivision 3,~~ sections 245.7351 to 245.736 shall be established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every ~~three~~ two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) the CCBHC daily bundled rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a CCBHC daily bundled rate system that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; ~~and~~

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update~~.~~; and

(10) payment for designated collaborating organization services is included within the scope of the CCBHC daily bundled rate, and designated collaborating organization encounters must be treated as CCBHC encounters for purposes of establishing the CCBHC daily bundled rate. Payment must be provided directly to the designated collaborating organization from the CCBHC based on agreed upon contractual service rates. These rates must be reflective of fair market value.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments

for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) A CCBHC must comply with the commissioner's quality assurance reporting requirements including any required reporting of encounter data, clinical outcomes data, and quality data.

Sec. 46. Minnesota Statutes 2022, section 260E.09, is amended to read:

260E.09 REPORTING REQUIREMENTS.

(a) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required under section 260E.06, subdivision 1, to report shall be followed

within 72 hours, exclusive of weekends and holidays, by a report in writing to the appropriate police department, the county sheriff, the agency responsible for assessing or investigating the report, or the local welfare agency.

(b) Any report shall be of sufficient content to identify the child, any person believed to be responsible for the maltreatment of the child if the person is known, the nature and extent of the maltreatment, and the name and address of the reporter. The local welfare agency or agency responsible for assessing or investigating the report shall accept a report made under section 260E.06 notwithstanding refusal by a reporter to provide the reporter's name or address as long as the report is otherwise sufficient under this paragraph.

(c) Notwithstanding paragraph (a), upon implementation of the provider licensing and reporting hub, an individual required to report under section 260E.06, subdivision 1, may submit a written report in the hub in a manner prescribed by the commissioner and is not required to make an oral report. Individuals submitting a report through the hub must comply with the timelines in paragraph (a).

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

Sec. 47. Minnesota Statutes 2022, section 270B.14, subdivision 1, is amended to read:

Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request of the commissioner of human services, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

(b) Data that may be disclosed are limited to data relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.

(c) The commissioner of human services may request data only for the purposes of carrying out the child support enforcement program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 256.978.

(d) The commissioner shall provide the records and information necessary to administer the supplemental housing allowance to the commissioner of human services.

(e) At the request of the commissioner of human services, the commissioner of revenue shall electronically match the Social Security numbers and names of participants in the telephone assistance plan operated under sections 237.69 to 237.71, with those of property

tax refund filers, and determine whether each participant's household income is within the eligibility standards for the telephone assistance plan.

(f) The commissioner may provide records and information collected under sections 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234. Upon the written agreement by the United States Department of Health and Human Services to maintain the confidentiality of the data, the commissioner may provide records and information collected under sections 295.50 to 295.59 to the Centers for Medicare and Medicaid Services section of the United States Department of Health and Human Services for purposes of meeting federal reporting requirements.

(g) The commissioner may provide records and information to the commissioner of human services as necessary to administer the early refund of refundable tax credits.

(h) The commissioner may disclose information to the commissioner of human services as necessary for income verification for eligibility and premium payment under the MinnesotaCare program, under section 256L.05, subdivision 2, as well as the medical assistance program under chapter 256B.

(i) The commissioner may disclose information to the commissioner of human services necessary to verify whether applicants or recipients for the Minnesota family investment program, general assistance, the Supplemental Nutrition Assistance Program (SNAP), Minnesota supplemental aid program, and child care assistance have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

(j) The commissioner may disclose information to the commissioner of human services necessary to verify income for purposes of calculating parental contribution amounts under section 252.27, subdivision 2a.

(k) The commissioner shall disclose information to the commissioner of human services to verify the income and tax identification information of:

(1) an applicant under section 245A.04, subdivision 1;

(2) an applicant under section 245I.20;

(3) an applicant under section 245H.03;

(4) a license holder; or

(5) a certification holder.

Sec. 48. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS AND MENTAL HEALTH SERVICE CERTIFICATIONS TRANSITION TO LICENSURE.**

(a) The commissioner of human services must transition all of the following mental health services from certification under Minnesota Statutes, chapters 245 and 256B, to licensure under Minnesota Statutes, chapter 245A, according to the Mental Health Uniform Service Standards in Minnesota Statutes, chapter 245I, to be effective on or before January 1, 2026:

(1) certified community behavioral health clinics;

(2) adult rehabilitative mental health services;

(3) mobile mental health crisis response services;

(4) children's therapeutic services and supports; and

(5) community mental health centers.

(b) No later than January 1, 2025, the commissioner must submit the proposed legislation necessary to implement the transition in paragraph (a) to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health services.

(c) The commissioner must consult with stakeholders to develop the legislation described in paragraph (b).

Sec. 49. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; CHANGES TO RESIDENTIAL ADULT MENTAL HEALTH PROGRAM LICENSING REQUIREMENTS.**

(a) The commissioner of human services must consult with stakeholders to determine the changes to residential adult mental health program licensing requirements in Minnesota Rules, parts 9520.0500 to 9520.0670, necessary to:

(1) update requirements for category I programs to align with current mental health practices, client rights for similar services, and health and safety needs of clients receiving services;

(2) remove category II classification and requirements; and

(3) add licensing requirements to the rule for the Forensic Mental Health Program.

(b) The commissioner must use existing authority in Minnesota Statutes, chapter 245A, to amend Minnesota Rules, parts 9520.0500 to 9520.0670, based on the stakeholder consultation in paragraph (a) and additional changes as determined by the commissioner.

Sec. 50. **REPEALER.**

Minnesota Statutes 2022, section 245.735, subdivision 3, is repealed.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 14
FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 15, and Laws 2021, First Special Session chapter 7, article 16, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2023" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2023.

	APPROPRIATIONS Available for the Year Ending June 30 2023
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (1,363,772,000)**
Appropriations by Fund	
2023	
General	(1,156,872,000)
Health Care Access	(196,098,000)
Federal TANF	(10,802,000)
Subd. 2. **Forecasted Programs**	
(a) **Minnesota Family Investment Program**	

(MFIP)/Diversionary Work Program (DWP)

	Appropriations by Fund
	2023
General	3,636,000
Federal TANF	(10,802,000)

(b) **MFIP Child Care Assistance** (36,957,000)

(c) **General Assistance** (521,000)

(d) **Minnesota Supplemental Aid** (5,000)

(e) **Housing Support** 221,000

(f) **Northstar Care for Children** (12,670,000)

(g) **MinnesotaCare** (196,098,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund
	2023
General	(1,110,576,000)
Health Care Access	0

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 15

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively. "The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium" is fiscal years 2024 and 2025.

APPROPRIATIONS

Available for the Year

Ending June 30

2024 **2025**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 6,244,921,000 $ 6,489,006,000**

Appropriations by Fund

	2024	2025
General	4,949,348,000	4,597,204,000
State Government Special Revenue	4,776,000	5,284,000
Health Care Access	1,005,106,000	1,617,914,000
Federal TANF	285,691,000	286,604,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF maintenance of effort requirements, the commissioner may report as TANF maintenance of effort expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and Tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal expenditures; reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Limitations; exceptions.** The commissioner must not claim an amount of TANF maintenance of effort in excess of the 75 percent standard in Code of Federal

Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess maintenance of effort provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

(d) **Supplemental expenditures.** For the purposes of paragraph (d), the commissioner may supplement the maintenance of effort claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(e) **Reduction of appropriations; exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law does not apply if the grants or aids are federal TANF funds.

(f) **IT appropriations generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs must be incorporated into the service level agreement and paid to the Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(g) **Receipts for systems project.** Appropriations and federal receipts for information technology systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of the Minnesota IT Services funded by the legislature and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(h) **Federal SNAP education and training grants.** Federal funds available during fiscal years 2024 and 2025 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the

purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Central Office; Operations**

	Appropriations by Fund	
General	297,580,000	258,240,000
State Government Special Revenue	4,776,000	5,284,000
Health Care Access	18,857,000	20,754,000
Federal TANF	100,000	100,000

(a) **Administrative recovery; set-aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) the statewide data management system authorized in Minnesota Statutes, section 125A.744, subdivision 3;

(2) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 245.495, paragraph (b);

(3) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) targeted case management under Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) residential services for children with severe emotional disturbance under Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Base level adjustment.** The general fund base is $251,157,000 in fiscal year 2026 and $248,981,000 in fiscal year 2027. The state government special revenue base is $4,880,000 in fiscal year 2026 and $4,880,000 in fiscal year 2027.

Subd. 4. **Central Office; Children and Families**

	Appropriations by Fund	
General	40,568,000	42,523,000
Federal TANF	3,572,000	3,676,000

(a) $64,000 in fiscal year 2024 and $32,000 in fiscal year 2025 from the general fund are for a quadrennial review of child support guidelines. Funds will be transferred to the special revenue fund.

(b) **Base level adjustment.** The general fund base is $41,848,000 in fiscal year 2026 and $40,452,000 in fiscal year 2027.

Subd. 5. **Central Office; Health Care**

	Appropriations by Fund	
General	49,059,000	32,969,000
Health Care Access	28,168,000	28,168,000

(a) $1,350,000 in fiscal year 2024 is from the general fund to the commissioner of human services to improve the accessibility of Minnesota health care programs applications, forms, and other consumer support resources and services to enrollees with limited English proficiency.

(b) $510,000 in fiscal year 2024 and $1,020,000 in fiscal year 2025 is from the general fund for contracts with community-based organizations to facilitate conversations with applicants and enrollees in Minnesota health care programs to improve the application, enrollment, and service delivery experience in medical assistance and MinnesotaCare.

(c) The general fund base is $32,111,000 in fiscal year 2026 and $35,798,000 in fiscal year 2027.

Subd. 6. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	1,098,000	1,277,000

Subd. 7. **Central Office; Behavioral Health, Housing, and Deaf and Hard of Hearing Services**

	Appropriations by Fund	
General	30,483,000	31,113,000

(a) $150,000 in fiscal year 2025 is from the general fund and provides funding for evaluating outcomes for the additional grant funding for the expansion of base funding for the PATH grants. The base for this purpose is $0 in fiscal year 2026 and $150,000 in fiscal year 2027.

(b) $1,720,000 in fiscal year 2024 and $1,720,000 in fiscal year 2025 is from the general fund and provides funding for an online behavioral health program locator with continued expansion of the provider database allowing people to research and access mental

health and substance use disorder treatment options.

(c) **Base level adjustment.** The general fund base is $30,752,000 in fiscal year 2026 and $30,902,000 in fiscal year 2027.

Subd. 8. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund	
General	84,134,000	86,417,000
Federal TANF	114,075,000	114,884,000

Subd. 9. **Forecasted Programs; MFIP Child Care Assistance**	46,989,000	150,099,000
Subd. 10. **Forecasted Programs; General Assistance**	72,248,000	81,553,000

The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2024 and $6,729,812 in fiscal year 2025. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 11. **Forecasted Programs; Minnesota Supplemental Aid**	56,195,000	57,930,000
Subd. 12. **Forecasted Programs; Housing Support**	212,572,000	222,635,000
Subd. 13. **Forecasted Programs; Northstar Care for Children**	120,060,000	127,740,000
Subd. 14. **Forecasted Programs; MinnesotaCare**	84,028,000	56,028,000

These appropriations are from the health care access fund.

Subd. 15. **Forecasted Programs; Medical Assistance**

	Appropriations by Fund	
General	3,249,235,000	2,723,857,000
Health Care Access	869,524,000	1,509,499,000

The health care access fund base is $612,099,000 in fiscal year 2026, $1,134,585,000 in fiscal year 2027, and $612,099,000 in fiscal year 2028.

Subd. 16. **Forecasted Programs; Behavioral Health Fund** 156,000 264,000

Subd. 17. **Grant Programs; Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	96,311,000	96,311,000

Subd. 18. **Grant Programs; BSF Child Care Grants** 68,402,000 119,785,000

The general fund base is $145,462,000 in fiscal year 2026 and $142,412,000 in fiscal year 2027.

Subd. 19. **Grant Programs; Child Care Development Grants** 170,337,000 177,656,000

(a) **Child care retention program.** $120,000,000 in fiscal year 2024 and $168,704,000 in fiscal year 2025 are for the child care retention program payments under Minnesota Statutes, section 119B.27. The base for this program is $161,700,000 in fiscal year 2026 and $161,714,000 in fiscal year 2027. Funds appropriated for this purpose in each fiscal year are available for two fiscal years.

(b) **Transition grant program.** $46,550,000 in fiscal year 2024 is for transition grants for child care providers that intend to participate in the child care retention program. This onetime appropriation is available until June 30, 2025.

(c) **Base level adjustment.** The general fund base is $170,652,000 in fiscal year 2026 and $170,667,000 in fiscal year 2027.

Subd. 20. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 21. **Grant Programs; Children's Services Grants**

Appropriations by Fund		
General	84,024,000	105,668,000
Federal TANF	140,000	140,000

(a) **Mille Lacs Band of Ojibwe American Indian child welfare initiative.** $3,337,000 in fiscal year 2024 and $5,294,000 is fiscal year 2025 is from the general fund to support activities necessary for the Mille Lacs Band of Ojibwe to join the American Indian child welfare initiative. The base is $7,893,000 in fiscal year 2026 and $7,893,000 in fiscal year 2027.

(b) **Leech Lake Band of Ojibwe American Indian child welfare initiative.** $1,848,000 in fiscal year 2024 and $1,848,000 is fiscal year 2025 is from the general fund to the Leech Lake Band of Ojibwe to participate in the American Indian child welfare initiative.

(c) **Red Lake Band of Chippewa American Indian child welfare initiative.** $3,000,000 in fiscal year 2024 and $3,000,000 is fiscal year 2025 is from the general fund to the Red Lake Band of Chippewa to participate in the American Indian child welfare initiative.

(d) **Staffing increase for Tribal nations.** $800,000 in fiscal year 2024 and $800,000 in fiscal year 2025 is from the general fund for

Tribal nations to expand staff capacity to provide child welfare services.

(e) $764,000 in fiscal year 2024 and $764,000 in fiscal year 2025 from the general fund is for grants for kinship navigator services and grants to Tribal nations for kinship navigator services. The base is $750,000 in fiscal year 2026 and $750,000 in fiscal year 2027.

(f) $6,100,000 in fiscal year 2024 and $9,800,000 in fiscal year 2025 are for Family First Prevention and Early Intervention Grants pursuant to Minnesota Statutes, section 260.014.

(g) $3,000,000 in fiscal year 2024 and $7,000,000 in fiscal year 2025 are for grants to support prevention and early intervention services to implement and build upon Minnesota's Family First Prevention Services Act Title IV-E Prevention Services plan under Minnesota Statutes, section 260.014. The base includes $10,000,000 in fiscal year 2026 and $10,000,000 in fiscal year 2027.

(h) $450,000 in fiscal year 2024 and $450,000 in fiscal year 2025 are for grants to one or more grantees to establish and manage a pool of state-funded qualified individuals to assess potential out-of-home placement of a child in a qualified residential treatment program.

(i) $1,958,000 in fiscal year 2024 and $2,095,000 in fiscal year 2025 is from the general fund for the STAY in the community program, pursuant Minnesota Statutes, section 260C.452. Funds are available until June 30, 2025.

(j) $600,000 in fiscal year 2024 and $1,200,000 in fiscal year 2025 is from the general fund for the support beyond 21 program pursuant to Minnesota Statutes, section 256.4792. Funds are available until June 30, 2025.

(k) $800,000 in fiscal year 2024 and $800,000 in fiscal year 2025 is from the general fund for minor connect program pursuant to Minnesota Statutes, section 256K.47. Funds are available until June 30, 2025.

(l) $3,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 is from the general fund to provide grants to counties and American Indian child welfare initiative Tribes to be used to reduce extended foster care caseload sizes. Funds are available until June 30, 2025.

(m) $770,000 in fiscal year 2024 and $770,000 in fiscal year 2025 for an increase in the public private adoption initiative in order to carry out the commissioner's duties under Minnesota Statutes, section 256.01, subdivision 2, paragraph (h).

(n) Grants to community resource centers; $0 in fiscal year 2024 and $11,250,000 in fiscal year 2025 from the general fund is for community resource centers, pursuant to Minnesota Statutes, section 260C.30. The base is $14,528,000 in fiscal year 2026 and $14,528,000 in fiscal year 2027.

(o) **Base level adjustment.** The general fund base is $114,766,000 in fiscal year 2026 and $114,766,000 in fiscal year 2027.

Subd. 22. **Grant Programs; Children and Community Service Grants**	60,856,000	60,856,000
Subd. 23. **Grant Programs; Children and Economic Support Grants**	90,609,000	77,109,000

(a) $400,000 in fiscal year 2024 is from the general fund to the commissioner for start-up grants to the Red Lake Nation, White Earth Nation, and Mille Lacs Band of Ojibwe to develop a fraud prevention program. This onetime appropriation is available until June 30, 2025.

(b) **Emergency services program.** $15,000,000 in fiscal year 2024 and $20,000,000 in fiscal year 2025 from the general fund for the emergency services program under Minnesota Statutes, section 256E.36. Grant allocation balances in the first year do not cancel but are available in the second year of the biennium. The base includes $35,000,000 in fiscal year 2026 and $35,000,000 in fiscal year 2027.

(c) **Tribal food sovereignty grants.** $3,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 are from the general fund for grants to support food security among Tribal nations and American Indian communities under Minnesota Statutes, section 256E.341. Funds are available until June 30, 2025. The base includes $2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027.

(d) **Food support grants.** $6,000,000 in fiscal year 2024 and $6,000,000 in fiscal year 2025 is from the general fund for the Minnesota food shelf program under Minnesota Statutes,

section 256E.34. Funds are available until June 30, 2025.

(e) **Outreach and application assistance for SNAP-eligible Minnesotans.** $3,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 is from the general fund to provide outreach and application assistance to eligible Minnesotans who are not enrolled in SNAP. Funds may be used for support organizations across the state to provide education, information, and assistance to help Minnesotans apply for SNAP using culturally relevant and community-driven approaches.

(f) **Capital for emergency food distribution facilities.** $19,000,000 in fiscal year 2024 is for improving and expanding the infrastructure of food shelf facilities across the state, including adding freezer or cooler space and dry storage space, improving the safety and sanitation of existing food shelves, and addressing deferred maintenance or other facility needs of existing food shelves. Grant money shall be made available to nonprofit organizations, federally recognized Tribes, and local units of government. This is a onetime appropriation and is available until June 30, 2027.

(g) **Base level adjustment.** The general fund base is $93,609,000 in fiscal year 2026 and $93,609,000 in fiscal year 2027.

Subd. 24. **Grant Programs; Health Care Grants**

	Appropriations by Fund	
General	5,811,000	7,297,000
Health Care Access	4,529,000	3,465,000

(a) $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 is from the general fund to the commissioner of human services for funding to the Indian Health Board of Minneapolis to support continued access to health care coverage through Minnesota health care programs, improve access to quality care, and increase vaccination rates among urban American Indians. The general fund base for this appropriation is $1,000,000 in fiscal year 2026 and $0 in fiscal year 2027.

(b) $2,000,000 in fiscal year 2025 is from the general fund for grants to demonstration participants in a project to develop innovative cost of care payment models that integrate social services and health care service delivery for Medicaid beneficiaries. The base includes for this proposal $1,260,000 in fiscal year 2026 and $1,260,000 in fiscal year 2027, and the base is $0 in fiscal year 2028.

(c) $1,064,000 in fiscal year 2024 is from the health care access fund to the commissioner of human services for grants to organizations with a MNsure grant services navigator assister contract in good standing as of June 30, 2022. Funds are available until June 30, 2025. This is a onetime appropriation.

(d) **Base level adjustment.** The general fund base is $7,071,000 in fiscal year 2026 and $6,071,000 in fiscal year 2027.

Subd. 25. **Grant Programs; Deaf and Hard-of-Hearing Grants**	2,886,000	2,886,000
Subd. 26. **Grant Programs; Disabilities Grants**	500,000	2,000,000

$500,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are from the general fund

for the transition to community grant initiative grant funding under the Laws 2021, First Special Session chapter 7, article 17, section 6.

Subd. 27. **Grant Programs; Housing Support Grants** 18,634,000 10,364,000

Subd. 28. **Grant Programs; Adult Mental Health Grants**

Appropriations by Fund

General 128,537,000 142,175,000

(a) $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are for adult mental health initiative grants to the White Earth Nation. This is a onetime appropriation.

(b) $1,375,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025 are from the general fund for the transition to community grant initiative grant funding under Laws 2021, First Special Session chapter 7, article 17, section 6.

(c) $4,000,000 in fiscal year 2024 and $8,000,000 in fiscal year 2025 are from the general fund for the mobile crisis grants under the Laws 2021, First Special Session chapter 7, article 17, section 11.

(d) $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for mobile crisis funds to Tribal nations.

(e) **Base level adjustment.** The general fund base is $152,483,000 in fiscal year 2026 and $152,465,000 in fiscal year 2027.

Subd. 29. **Grant Programs; Child Mental Health Grants** 48,530,000 46,676,000

(a) $4,400,000 in fiscal year 2024 and $4,400,000 in fiscal year 2025 are from the general fund for school-linked behavioral health services in intermediate school districts.

(b) $1,050,000 in fiscal year 2024 and $1,050,000 in fiscal year 2025 are from the general fund for psychiatric residential treatment facilities specialization grants for staffing costs to treat and support behavioral health conditions and support children and families.

(c) $1,250,000 in fiscal year 2024 and $1,250,000 in fiscal year 2025 are from the general fund for emerging mood disorder grants for evidence-informed interventions for youth and young adults who are at higher risk of developing a mood disorder or are already experiencing an emerging mood disorder such as major depression or bipolar disorder.

(d) $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for grants to implement the mobile response and stabilization services model. The model is to promote access to crisis response services, reduce admissions to psychiatric hospitalizations and out-of-home placement services, which are expensive and traumatic for children, youth, and families.

(e) $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund and must be used to provide grant funding to mental health consultants throughout the state including Tribal nations for expertise in young children's development and early childhood services.

(f) **Base level adjustment.** The general fund base is $50,926,000 in fiscal year 2026 and $50,926,000 in fiscal year 2027.

Subd. 30. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	1,350,000	1,350,000

Subd. 31. **Technical Activities** 71,493,000 71,493,000

This appropriation is from the federal TANF fund.

Sec. 3. **NAVIGATOR ASSISTER GRANTS.**

$1,936,000 in fiscal year 2023 is appropriated from the health care access fund to the commissioner of human services for grants to organizations with a MNsure grant services navigator assister contract in good standing as of June 30, 2023. The grant payment to each organization must be in proportion to the number of medical assistance and MinnesotaCare enrollees each organization assisted that resulted in a successful enrollment in the second quarter of fiscal years 2020 and 2022, as determined by MNsure's navigator payment process. This is a onetime appropriation and is available until June 30, 2025.

Sec. 4. **ASSET DISREGARDS.**

$351,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of human services to implement a temporary asset disregard program in the medical assistance program. This is a onetime appropriation.

Sec. 5. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 32, as amended by Laws 2022, chapter 98, article 15, section 7, subdivision 32, is amended to read:

Subd. 32. **Grant Programs; Child Mental Health Grants** 30,167,000 30,182,000

(a) **Children's Residential Facilities.** $1,964,000 in fiscal year 2022 and $1,979,000 in fiscal year 2023 are to reimburse counties and Tribal governments for a portion of the costs of treatment in children's residential

facilities. The commissioner shall distribute the appropriation to counties and Tribal governments proportionally based on a methodology developed by the commissioner. The ~~fiscal year 2022 appropriation is available until June 30, 2023~~ base for this activity is $0 in fiscal year 2025.

(b) **Base Level Adjustment.** The general fund base is $29,580,000 in fiscal year 2024 and ~~$27,705,000~~ $25,726,000 in fiscal year 2025.

Sec. 6. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2025, within fiscal years among the MFIP; general assistance; medical assistance; MinnesotaCare; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid program; group residential housing program; the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N; and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioners shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

62J.692 MEDICAL EDUCATION.

Subd. 4a. **Alternative distribution.** If federal approval is not received for the formula described in subdivision 4, paragraphs (a) and (b), 100 percent of available medical education and research funds shall be distributed based on a distribution formula that reflects a summation of two factors:

(1) a public program volume factor, that is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and

(2) a supplemental public program volume factor, that is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.

Subd. 7. **Transfers from commissioner of human services.** Of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), $21,714,000 shall be distributed as follows:

(1) $2,157,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;

(2) $1,035,360 shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education;

(3) $17,400,000 shall be distributed by the commissioner to the University of Minnesota Board of Regents for purposes of medical education;

(4) $1,121,640 shall be distributed by the commissioner to clinical medical education dental innovation grants in accordance with subdivision 7a; and

(5) the remainder of the amount transferred according to section 256B.69, subdivision 5c, clauses (1) to (4), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a).

Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner shall award grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner, in consultation with the commissioner of human services, shall consider the following:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) the efficiency in the use of the funding; and

(5) the priority level of the project in relation to state clinical education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding the innovations grants in order to ensure that the priorities meet the changing workforce needs of the state.

119B.03 BASIC SLIDING FEE PROGRAM.

Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school diploma or commissioner of education-selected high school equivalency certification or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

(1) child care needs of minor parents;

(2) child care needs of parents under 21 years of age; and

(3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(d) Fourth priority must be given to families in which at least one parent is a veteran as defined under section 197.447.

(e) Families under paragraph (b) must be added to the basic sliding fee waiting list on the date they begin the transition year under section 119B.011, subdivision 20, and must be moved into the basic sliding fee program as soon as possible after they complete their transition year.

137.38 EDUCATION AND TRAINING OF PRIMARY CARE PHYSICIANS.

Subdivision 1. **Condition.** If the Board of Regents accepts the amount transferred under section 62J.692, subdivision 7, clause (1), to be used for the purposes described in sections 137.38 to 137.40, it shall comply with the duties for which the transfer is made.

245.735 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES.

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process 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 process and requirements. Entities that choose to be CCBHCs must:

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

(2) 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;

(3) ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) 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;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) 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 paragraph (b);

(7) 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. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

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

(9) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations;

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

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

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

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

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

(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(16) provide services that comply with the evidence-based practices described in paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8), as applicable when peer services are provided.

(b) If a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the following criteria as a designated collaborating organization:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) 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, as described in subdivision 4, before granting variances under this provision. For the 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.

(e) 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, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall 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 and certification process.

245C.02 DEFINITIONS.

Subd. 14b. **Public law background study.** "Public law background study" means a background study conducted by the commissioner pursuant to section 245C.032.

245C.032 PUBLIC LAW BACKGROUND STUDIES.

Subdivision 1. **Public law background studies.** (a) Notwithstanding all other sections of chapter 245C, the commissioner shall conduct public law background studies exclusively in accordance with this section. The commissioner shall conduct a public law background study under this section for an individual having direct contact with persons served by a licensed sex offender treatment program under chapters 246B and 253D.

(b) All terms in this section shall have the definitions provided in section 245C.02.

(c) The commissioner shall conduct public law background studies according to the following:

(1) section 245C.04, subdivision 1, paragraphs (a), (b), (d), (g), (h), and (i), subdivision 4a, and subdivision 7;

(2) section 245C.05, subdivision 1, paragraphs (a) and (d), subdivisions 2, 2c, and 2d, subdivision 4, paragraph (a), clauses (1) and (2), subdivision 5, paragraphs (b) to (f), and subdivisions 6 and 7;

(3) section 245C.051;

(4) section 245C.07, paragraphs (a), (b), (d), and (f);

(5) section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), paragraphs (b), (c), (d), and (e), subdivision 3, and subdivision 4, paragraphs (a), (c), (d), and (e);

(6) section 245C.09, subdivisions 1 and 2;

(7) section 245C.10, subdivision 9;

(8) section 245C.13, subdivision 1, and subdivision 2, paragraph (a), and paragraph (c), clauses (1) to (3);

(9) section 245C.14, subdivisions 1 and 2;

(10) section 245C.15;

(11) section 245C.16, subdivision 1, paragraphs (a), (b), (c), and (f), and subdivision 2, paragraphs (a) and (b);

(12) section 245C.17, subdivision 1, subdivision 2, paragraph (a), clauses (1) to (3), clause (6), item (ii), subdivision 3, paragraphs (a) and (b), paragraph (c), clauses (1) and (2), items (ii) and (iii), paragraph (d), clauses (1) and (2), item (ii), and paragraph (e);

(13) section 245C.18, paragraph (a);

(14) section 245C.19;

(15) section 245C.20;

(16) section 245C.21, subdivision 1, subdivision 1a, paragraph (c), and subdivisions 2, 3, and 4;

(17) section 245C.22, subdivisions 1, 2, and 3, subdivision 4, paragraphs (a) to (c), subdivision 5, paragraphs (a), (b), and (d), and subdivision 6;

(18) section 245C.23, subdivision 1, paragraphs (a) and (b), and subdivision 2, paragraphs (a) to (c);

(19) section 245C.24, subdivision 2, paragraph (a);

(20) section 245C.25;

(21) section 245C.27;

(22) section 245C.28;

(23) section 245C.29, subdivision 1, and subdivision 2, paragraphs (a) and (c);

(24) section 245C.30, subdivision 1, paragraphs (a) and (d), and subdivisions 3 to 5;

(25) section 245C.31; and

(26) section 245C.32.

Subd. 2. **Classification of public law background study data; access to information.** All data obtained by the commissioner for a background study completed under this section shall be classified as private data.

245C.11 BACKGROUND STUDY; COUNTY AGENCIES.

Subd. 3. **Criminal history data.** County agencies shall have access to the criminal history data in the same manner as county licensing agencies under this chapter for purposes of background studies completed before the implementation of NETStudy 2.0 by county agencies on legal nonlicensed child care providers to determine eligibility for child care funds under chapter 119B.

245C.30 VARIANCE FOR A DISQUALIFIED INDIVIDUAL.

Subd. 1a. **Public law background study variances.** For a variance related to a public law background study conducted under section 245C.032, the variance shall state the services that may be provided by the disqualified individual and state the conditions with which the license holder or applicant must comply for the variance to remain in effect. The variance shall not state the reason for the disqualification.

256.8799 SUPPLEMENTAL NUTRITION ASSISTANCE OUTREACH PROGRAM.

Subdivision 1. **Establishment.** The commissioner of human services shall establish, in consultation with the representatives from community action agencies, a statewide outreach program to better inform potential recipients of the existence and availability of Supplemental Nutrition Assistance Program (SNAP) benefits under SNAP. As part of the outreach program, the commissioner and community action agencies shall encourage recipients in the use of SNAP benefits at food cooperatives. The commissioner shall explore and pursue federal funding sources, and specifically, apply for funding from the United States Department of Agriculture for the SNAP outreach program.

Subd. 2. **Administration of the program.** A community association representing community action agencies under section 256E.31, in consultation with the commissioner shall administer the outreach program, issue the request for proposals, and review and approve the potential grantee's plan. Grantees shall comply with the monitoring and reporting requirements as developed by the commissioner in accordance with subdivision 4, and must also participate in the evaluation process as directed by the commissioner. Grantees must successfully complete one year of outreach and demonstrate compliance with all monitoring and reporting requirements in order to be eligible for additional funding.

Subd. 3. **Plan content.** In approving the plan, the association shall evaluate the plan and give highest priority to a plan that:

(1) targets communities in which 50 percent or fewer of the residents with incomes below 125 percent of the poverty level receive SNAP benefits;

(2) demonstrates that the grantee has the experience necessary to administer the program;

(3) demonstrates a cooperative relationship with the local county social service agencies;

(4) provides ways to improve the dissemination of information on SNAP as well as other assistance programs through a statewide hotline or other community agencies;

(5) provides direct advocacy consisting of face-to-face assistance with the potential applicants;

(6) improves access to SNAP by documenting barriers to participation and advocating for changes in the administrative structure of the program; and

(7) develops strategies for combatting community stereotypes about SNAP benefit recipients and SNAP, misinformation about the program, and the stigma associated with using SNAP benefits.

Subd. 4. **Coordinated development.** The commissioner shall consult with representatives from the United States Department of Agriculture, Minnesota Community Action Association, Food First Coalition, Minnesota Department of Human Services, Urban Coalition/University of Minnesota extension services, county social service agencies, local social service agencies, and organizations that have previously administered the state-funded SNAP outreach programs to:

(1) develop the reporting requirements for the program;

(2) develop and implement the monitoring of the program;

(3) develop, coordinate, and assist in the evaluation process; and

(4) provide an interim report to the legislature by January 1997, and a final report to the legislature by January 1998, which includes the results of the evaluation and recommendations.

256.9864 REPORTS BY RECIPIENT.

(a) An assistance unit with a recent work history or with earned income shall report monthly to the county agency on income received and other circumstances affecting eligibility or assistance amounts. All other assistance units shall report on income and other circumstances affecting eligibility and assistance amounts, as specified by the state agency.

(b) An assistance unit required to submit a report on the form designated by the commissioner and within ten days of the due date or the date of the significant change, whichever is later, or otherwise report significant changes which would affect eligibility or assistance amounts, is considered to have continued its application for assistance effective the date the required report is received by the county agency, if a complete report is received within a calendar month in which assistance was received.

256B.69 PREPAID HEALTH PLANS.

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. After January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and $49,552,000 in fiscal year 2014 and thereafter.

256J.08 DEFINITIONS.

Subd. 10. **Budget month.** "Budget month" means the calendar month which the county agency uses to determine the income or circumstances of an assistance unit to calculate the amount of the assistance payment in the payment month.

Subd. 53. **Lump sum.** "Lump sum" means nonrecurring income as described in section 256P.06, subdivision 3, clause (2), item (ix).

Subd. 61. **Monthly income test.** "Monthly income test" means the test used to determine ongoing eligibility and the assistance payment amount according to section 256J.21.

Subd. 62. **Nonrecurring income.** "Nonrecurring income" means a form of income which is received:

(1) only one time or is not of a continuous nature; or

(2) in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subd. 81. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of the assistance payment in which the payment month is the second month after the budget month.

Subd. 83. **Significant change.** "Significant change" means a decline in gross income of the amount of the disregard as defined in section 256P.03 or more from the income used to determine the grant for the current month.

256J.30 APPLICANT AND PARTICIPANT REQUIREMENTS AND RESPONSIBILITIES.

Subd. 5. **Monthly MFIP household reports.** Each assistance unit with a member who has earned income or a recent work history, and each assistance unit that has income deemed to it from a financially responsible person must complete a monthly MFIP household report form. "Recent work history" means the individual received earned income in the report month or any of the previous three calendar months even if the earnings are excluded. To be complete, the MFIP household report form must be signed and dated by the caregivers no earlier than the last day of the reporting period. All questions required to determine assistance payment eligibility must be answered, and documentation of earned income must be included.

Subd. 7. **Due date of MFIP household report form.** An MFIP household report form must be received by the county agency by the eighth calendar day of the month following the reporting period covered by the form. When the eighth calendar day of the month falls on a weekend or holiday, the MFIP household report form must be received by the county agency the first working day that follows the eighth calendar day.

Subd. 8. **Late MFIP household report forms.** (a) Paragraphs (b) to (e) apply to the reporting requirements in subdivision 7.

(b) When the county agency receives an incomplete MFIP household report form, the county agency must immediately contact the caregiver by phone or in writing to acquire the necessary information to complete the form.

(c) The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month. When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(d) An assistance unit required to submit an MFIP household report form is considered to have continued its application for assistance if a complete MFIP household report form is received within a calendar month after the month in which the form was due and assistance shall be paid for the period beginning with the first day of that calendar month.

(e) A county agency must allow good cause exemptions from the reporting requirements under subdivision 5 when any of the following factors cause a caregiver to fail to provide the county agency with a completed MFIP household report form before the end of the month in which the form is due:

(1) an employer delays completion of employment verification;

(2) a county agency does not help a caregiver complete the MFIP household report form when the caregiver asks for help;

(3) a caregiver does not receive an MFIP household report form due to mistake on the part of the department or the county agency or due to a reported change in address;

(4) a caregiver is ill, or physically or mentally incapacitated; or

(5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed MFIP household report form before the end of the month in which the form is due.

256J.33 PROSPECTIVE AND RETROSPECTIVE MFIP ELIGIBILITY.

Subd. 3. **Retrospective eligibility.** After the first two months of MFIP eligibility, a county agency must continue to determine whether an assistance unit is prospectively eligible for the payment month by looking at all factors other than income and then determine whether the assistance unit is retrospectively income eligible by applying the monthly income test to the income from the budget month. When the monthly income test is not satisfied, the assistance payment must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subd. 4. **Monthly income test.** A county agency must apply the monthly income test retrospectively for each month of MFIP eligibility. An assistance unit is not eligible when the countable income equals or exceeds the MFIP standard of need or the family wage level for the assistance unit. The income applied against the monthly income test must include:

(1) gross earned income from employment as described in chapter 256P, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(2) gross earned income from self-employment less deductions for self-employment expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(3) unearned income as described in section 256P.06, subdivision 3, after deductions for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36;

(4) gross earned income from employment as determined under clause (1) which is received by a member of an assistance unit who is a minor child or minor caregiver and less than a half-time student;

(5) child support received by an assistance unit, excluded under section 256P.06, subdivision 3, clause (2), item (xvi);

(6) spousal support received by an assistance unit;

(7) the income of a parent when that parent is not included in the assistance unit;

(8) the income of an eligible relative and spouse who seek to be included in the assistance unit; and

(9) the unearned income of a minor child included in the assistance unit.

Subd. 5. **When to terminate assistance.** When an assistance unit is ineligible for MFIP assistance for two consecutive months, the county agency must terminate MFIP assistance.

256J.34 CALCULATING ASSISTANCE PAYMENTS.

Subdivision 1. **Prospective budgeting.** A county agency must use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in this state for at least one payment month preceding the first month of payment under a current application. Notwithstanding subdivision 3, paragraph (a), clause (2), a county agency must use prospective budgeting for the first two months for a person who applies to be added to an assistance unit. Prospective budgeting is not subject to overpayments or underpayments unless fraud is determined under section 256.98.

(a) The county agency must apply the income received or anticipated in the first month of MFIP eligibility against the need of the first month. The county agency must apply the income received or anticipated in the second month against the need of the second month.

(b) When the assistance payment for any part of the first two months is based on anticipated income, the county agency must base the initial assistance payment amount on the information available at the time the initial assistance payment is made.

(c) The county agency must determine the assistance payment amount for the first two months of MFIP eligibility by budgeting both recurring and nonrecurring income for those two months.

Subd. 2. **Retrospective budgeting.** The county agency must use retrospective budgeting to calculate the monthly assistance payment amount after the payment for the first two months has been made under subdivision 1.

Subd. 3. **Additional uses of retrospective budgeting.** Notwithstanding subdivision 1, the county agency must use retrospective budgeting to calculate the monthly assistance payment amount for the first two months under paragraphs (a) and (b).

(a) The county agency must use retrospective budgeting to determine the amount of the assistance payment in the first two months of MFIP eligibility:

(1) when an assistance unit applies for assistance for the same month for which assistance has been interrupted, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in this state, and the assistance payment for the immediately preceding month was determined retrospectively; or

(2) when a person applies in order to be added to an assistance unit, that assistance unit has received assistance in this state for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

(b) Except as provided in clauses (1) to (4), the county agency must use retrospective budgeting and apply income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit against the MFIP standard of need or family wage level to determine the assistance payment to be issued for the payment month.

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When an individual is removed from an assistance unit because the individual is no longer a minor child, the income of that individual is not budgeted retrospectively for payment months in which that individual is not a member of the assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against the child's needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Subd. 4. **Significant change in gross income.** The county agency must recalculate the assistance payment when an assistance unit experiences a significant change, as defined in section 256J.08, resulting in a reduction in the gross income received in the payment month from the gross income received in the budget month. The county agency must issue a supplemental assistance payment based on the county agency's best estimate of the assistance unit's income and circumstances for the payment month. Supplemental assistance payments that result from significant changes are limited to two in a 12-month period regardless of the reason for the change. Notwithstanding any other statute or rule of law, supplementary assistance payments shall not be made when the significant change in income is the result of receipt of a lump sum, receipt of an extra paycheck, business fluctuation in self-employment income, or an assistance unit member's participation in a strike or other labor action.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 10. **Treatment of lump sums.** (a) The agency must treat lump-sum payments as earned or unearned income. If the lump-sum payment is included in the category of income identified in subdivision 9, it must be treated as unearned income. A lump sum is counted as income in the month received and budgeted either prospectively or retrospectively depending on the budget cycle at the time of receipt. When an individual receives a lump-sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to paragraphs (a) to (c). A lump sum may not be carried over into subsequent months. Any funds that remain in the third month after the month of receipt are counted in the asset limit.

(b) For a lump sum received by an applicant during the first two months, prospective budgeting is used to determine the payment and the lump sum must be combined with other earned or unearned income received and budgeted in that prospective month.

(c) For a lump sum received by a participant after the first two months of MFIP eligibility, the lump sum must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

(d) When a lump sum, combined with other income under paragraphs (b) and (c), is less than the MFIP transitional standard for the appropriate payment month, the assistance payment must be reduced according to the amount of the countable income. When the countable income is greater than the MFIP standard or family wage level, the assistance payment must be suspended for the payment month.