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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2586

03/20/2025 Authored by Frederick, Virnig, Keeler, Momanyi-Hiltsley, Fischer and others
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

1.1 A bill for an act
1.2 relating to state-operated services; extending cost of care exemption for certain
1.3 committed persons and 48-hour rule for admissions; establishing the Priority
1.4 Admission Review Panel; requiring creation of a Direct Care and Treatment
1.5 admissions dashboard and a limited exemption for admissions from hospital
1.6 settings; requiring a report; amending Minnesota Statutes 2024, sections 246.54,
1.7 subdivisions 1a, 1b; 253B.10, subdivision 1.

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

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

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

1.13 (1) zero percent for the first 30 days;

1.14 (2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate
1.15 for the client; and

1.16 (3) 100 percent for each day during the stay, including the day of admission, when the
1.17 facility determines that it is clinically appropriate for the client to be discharged.

1.18 (b) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent
1.19 of the cost of care for days over 31 for clients who meet the criteria in paragraph (a), clause
1.20 (2), the county shall be responsible for paying the state only the remaining amount. The
1.21 county shall not be entitled to reimbursement from the client, the client's estate, or from the
1.22 client's relatives, except as provided in section 246.53.

2.1 (c) ~~Between July 1, 2023, and March 31~~ Beginning July 1, 2025, the county is not  
2.2 responsible for the cost of care under paragraph (a), clause (3), for a person who is committed  
2.3 as a person who has a mental illness and is dangerous to the public under section 253B.18  
2.4 and who is awaiting transfer to another state-operated facility or program. ~~This paragraph~~  
2.5 ~~expires March 31, 2025.~~

2.6 (d) ~~Between April 1, 2025, and June 30~~ Beginning July 1, 2025, the county is not  
2.7 responsible for the cost of care under paragraph (a), clause (3), for a person who is civilly  
2.8 committed, if the client is awaiting transfer:

2.9 (1) to a facility operated by the Department of Corrections; or

2.10 (2) to another state-operated facility or program, and the Direct Care and Treatment  
2.11 executive medical director's office or a designee has determined that:

2.12 (i) the client meets criteria for admission to that state-operated facility or program; and

2.13 (ii) the state-operated facility or program is the only facility or program that can  
2.14 reasonably serve the client. ~~This paragraph expires June 30, 2025.~~

2.15 (e) Notwithstanding any law to the contrary, the client is not responsible for payment  
2.16 of the cost of care under this subdivision.

2.17 **EFFECTIVE DATE.** This section is effective retroactively from March 30, 2025.

2.18 Sec. 2. Minnesota Statutes 2024, section 246.54, subdivision 1b, is amended to read:

2.19 Subd. 1b. **Community behavioral health hospitals.** (a) A county's payment of the cost  
2.20 of care provided at state-operated community-based behavioral health hospitals for adults  
2.21 and children shall be according to the following schedule:

2.22 (1) 100 percent for each day during the stay, including the day of admission, when the  
2.23 facility determines that it is clinically appropriate for the client to be discharged; and

2.24 (2) the county shall not be entitled to reimbursement from the client, the client's estate,  
2.25 or from the client's relatives, except as provided in section 246.53.

2.26 (b) ~~Between July 1, 2023, and March 31~~ Beginning July 1, 2025, the county is not  
2.27 responsible for the cost of care under paragraph (a), clause (1), for a person committed as  
2.28 a person who has a mental illness and is dangerous to the public under section 253B.18 and  
2.29 who is awaiting transfer to another state-operated facility or program. ~~This paragraph expires~~  
2.30 ~~March 31, 2025.~~

3.1 (c) ~~Between April 1, 2025, and June 30~~ Beginning July 1, 2025, the county is not  
3.2 responsible for the cost of care under paragraph (a), clause (1), for a person who is civilly  
3.3 committed, if the client is awaiting transfer:

3.4 (1) to a facility operated by the Department of Corrections; or

3.5 (2) to another state-operated facility or program, and the Direct Care and Treatment  
3.6 executive medical director's office or a designee has determined that:

3.7 (i) the client meets criteria for admission to that state-operated facility or program; and

3.8 (ii) the state-operated facility or program is the only facility or program that can  
3.9 reasonably serve the client. ~~This paragraph expires June 30, 2025.~~

3.10 (d) Notwithstanding any law to the contrary, the client is not responsible for payment  
3.11 of the cost of care under this subdivision.

3.12 **EFFECTIVE DATE.** This section is effective retroactively from March 30, 2025.

3.13 Sec. 3. Minnesota Statutes 2024, section 253B.10, subdivision 1, is amended to read:

3.14 Subdivision 1. **Administrative requirements.** (a) When a person is committed, the  
3.15 court shall issue a warrant or an order committing the patient to the custody of the head of  
3.16 the treatment facility, state-operated treatment program, or community-based treatment  
3.17 program. The warrant or order shall state that the patient meets the statutory criteria for  
3.18 civil commitment.

3.19 (b) The executive board shall prioritize civilly committed patients being admitted from  
3.20 jail or a correctional institution or who are referred to a state-operated treatment facility for  
3.21 competency attainment or a competency examination under sections 611.40 to 611.59 for  
3.22 admission to a medically appropriate state-operated direct care and treatment bed based on  
3.23 the decisions of physicians in the executive medical director's office, using a priority  
3.24 admissions framework. The framework must account for a range of factors for priority  
3.25 admission, including but not limited to:

3.26 (1) the length of time the person has been on a waiting list for admission to a  
3.27 state-operated direct care and treatment program since the date of the order under paragraph  
3.28 (a), or the date of an order issued under sections 611.40 to 611.59;

3.29 (2) the intensity of the treatment the person needs, based on medical acuity;

3.30 (3) the person's revoked provisional discharge status;

3.31 (4) the person's safety and safety of others in the person's current environment;

4.1 (5) whether the person has access to necessary or court-ordered treatment;

4.2 (6) distinct and articulable negative impacts of an admission delay on the facility referring  
4.3 the individual for treatment; and

4.4 (7) any relevant federal prioritization requirements.

4.5 Patients described in this paragraph must be admitted to a state-operated treatment program  
4.6 within 48 hours. The commitment must be ordered by the court as provided in section  
4.7 253B.09, subdivision 1, paragraph (d). Patients committed to a secure treatment facility or  
4.8 less restrictive setting as ordered by the court under section 253B.18, subdivisions 1 and 2,  
4.9 must be prioritized for admission to a state-operated treatment program using the priority  
4.10 admissions framework in this paragraph.

4.11 (c) Upon the arrival of a patient at the designated treatment facility, state-operated  
4.12 treatment program, or community-based treatment program, the head of the facility or  
4.13 program shall retain the duplicate of the warrant and endorse receipt upon the original  
4.14 warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must  
4.15 be filed in the court of commitment. After arrival, the patient shall be under the control and  
4.16 custody of the head of the facility or program.

4.17 (d) Copies of the petition for commitment, the court's findings of fact and conclusions  
4.18 of law, the court order committing the patient, the report of the court examiners, and the  
4.19 prepetition report, and any medical and behavioral information available shall be provided  
4.20 at the time of admission of a patient to the designated treatment facility or program to which  
4.21 the patient is committed. Upon a patient's referral to the executive board for admission  
4.22 pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or  
4.23 correctional facility that has provided care or supervision to the patient in the previous two  
4.24 years shall, when requested by the treatment facility or executive board, provide copies of  
4.25 the patient's medical and behavioral records to the executive board for purposes of  
4.26 preadmission planning. This information shall be provided by the head of the treatment  
4.27 facility to treatment facility staff in a consistent and timely manner and pursuant to all  
4.28 applicable laws.

4.29 (e) Patients described in paragraph (b) must be admitted to a state-operated treatment  
4.30 program within 48 hours of the Office of Executive Medical Director, under section 246C.09,  
4.31 or a designee determining that a medically appropriate bed is available. This paragraph  
4.32 expires on June 30, ~~2025~~ 2027.

4.33 (f) Within four business days of determining which state-operated direct care and  
4.34 treatment program or programs are appropriate for an individual, the executive medical

5.1 director's office or a designee must notify the source of the referral and the responsible  
 5.2 county human services agency, the individual being ordered to direct care and treatment,  
 5.3 and the district court that issued the order of the determination. The notice shall include  
 5.4 which program or programs are appropriate for the person's priority status. Any interested  
 5.5 person may provide additional information or request updated priority status about the  
 5.6 individual to the executive medical director's office or a designee while the individual is  
 5.7 awaiting admission. Updated priority status of an individual will only be disclosed to  
 5.8 interested persons who are legally authorized to receive private information about the  
 5.9 individual. When an available bed has been identified, the executive medical director's  
 5.10 office or a designee must notify the designated agency and the facility where the individual  
 5.11 is awaiting admission that the individual has been accepted for admission to a particular  
 5.12 state-operated direct care and treatment program and the earliest possible date the admission  
 5.13 can occur. The designated agency or facility where the individual is awaiting admission  
 5.14 must transport the individual to the admitting state-operated direct care and treatment  
 5.15 program no more than 48 hours after the offered admission date.

5.16 Sec. 4. **PRIORITY ADMISSIONS REVIEW PANEL.**

5.17 (a) The Priority Admissions Review Panel is established.

5.18 (b) The Direct Care and Treatment executive board shall appoint the members of the  
 5.19 panel. The panel must consist of all members who served on the Task Force on Priority  
 5.20 Admissions to State-Operated Treatment Programs under Laws 2023, chapter 61, article 8,  
 5.21 section 13, subdivision 2, and one member who has an active role as a union representative  
 5.22 representing staff at Direct Care and Treatment appointed by joint representatives of the  
 5.23 American Federation of State, County and Municipal Employees (AFSCME); Minnesota  
 5.24 Association of Professional Employees (MAPE); Minnesota Nurses Association (MNA);  
 5.25 Middle Management Association (MMA); and State Residential Schools Education  
 5.26 Association (SRSEA).

5.27 (c) The panel must:

5.28 (1) evaluate the 48-hour timeline for priority admissions required under Minnesota  
 5.29 Statutes, section 253B.10, subdivision 1, paragraph (b), and measure progress toward  
 5.30 implementing the recommendations of the task force;

5.31 (2) develop policy and legislative proposals related to the priority admissions timeline  
 5.32 in order to minimize litigation costs, maximize capacity in and access to direct care and  
 5.33 treatment programs, and address issues related to individuals awaiting admission to direct  
 5.34 care and treatment programs in jails and correctional institutions;

6.1 (3) by February 1, 2026, submit a written report to the chairs and ranking minority  
6.2 members of the legislative committees with jurisdiction over public safety and human  
6.3 services that includes legislative proposals to carry out recommendations; and

6.4 (4) review quarterly data provided by the executive board to measure the impact of  
6.5 changes, including:

6.6 (i) priority admission waitlist data, including the time each individual spends on the  
6.7 waitlist;

6.8 (ii) data regarding engagement by the admissions team;

6.9 (iii) priority notice data; and

6.10 (iv) other similar data relating to admissions.

6.11 **Sec. 5. DIRECT CARE AND TREATMENT ADMISSIONS DASHBOARD.**

6.12 (a) By January 1, 2026, the Direct Care and Treatment executive board must publish a  
6.13 publicly accessible dashboard on the agency's website regarding referrals under Minnesota  
6.14 Statutes, section 253B.10, subdivision 1, paragraph (b).

6.15 (b) The dashboard required under paragraph (a) must include data on:

6.16 (1) how many individuals are on the waitlists;

6.17 (2) how long the shortest, average, and longest wait times are for admission to Direct  
6.18 Care and Treatment facilities; and

6.19 (3) the number of referrals, admissions, and waitlists and the length of time of individuals  
6.20 on waitlists; and

6.21 (4) framework categories and referral sources.

6.22 (c) Any published data must be deidentified.

6.23 (d) Data on the dashboard are public data under Minnesota Statutes, section 13.03.

6.24 (e) The executive board must update the dashboard quarterly.

6.25 (f) The executive board must also include relevant admissions policies and contact  
6.26 information for the Direct Care and Treatment Central Preadmission Office on the dashboard  
6.27 required under paragraph (a).

6.28 (g) The executive board must provide information about an individual's relative placement  
6.29 on the waitlist upon request by the individual or the individual's legal representative.

6.30 Information about the individual's relative placement on the waitlist must be designated as

7.1 confidential under Minnesota Statutes, section 13.02, subdivision 3, if the information  
7.2 jeopardizes the health or wellbeing of the individual.

7.3 **Sec. 6. DIRECTION FOR LIMITED EXCEPTION FOR ADMISSIONS FROM**  
7.4 **HOSPITAL SETTINGS.**

7.5 (a) The commissioner of human services or a designee must immediately approve an  
7.6 exception to add up to ten patients per fiscal year who have been civilly committed and are  
7.7 in hospital settings to the admission waitlist for medically appropriate direct care and  
7.8 treatment beds under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b).

7.9 (b) The Direct Care and Treatment executive board is subject to the requirement under  
7.10 paragraph (a) on and after the transfer of duties on July 1, 2025, from the commissioner of  
7.11 human services to the executive board under Minnesota Statutes, section 246C.04.

7.12 (c) This section expires June 30, 2027.

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