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State of Minnesota

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HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. **729**

- 02/13/2025 Authored by Noor; Schomacker; Hansen, R.; Curran; Virnig and others
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy
- 04/07/2025 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
- 05/19/2025 Pursuant to Rule 4.20, returned to the Committee on Human Services Finance and Policy
- 04/07/2026 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

1.1 A bill for an act

1.2 relating to human services; modifying policy provisions relating to Direct Care

1.3 and Treatment, the Department of Health, health care, medical assistance provider

1.4 enrollment, aging and disability services, behavioral health, homelessness, housing,

1.5 and maltreatment of vulnerable adults; removing housing stabilization supports

1.6 provisions; requiring rulemaking; requiring release of initial Optum reports;

1.7 prohibiting Optum from disseminating private data; requiring reports; appropriating

1.8 money; amending Minnesota Statutes 2024, sections 3.7381; 13.04, subdivision

1.9 4a; 13.384, subdivision 1; 13.43, subdivision 5a; 13.46, subdivision 1; 62Q.75,

1.10 subdivision 4; 142B.01, subdivision 8; 144.56, subdivision 2b; 144.586, subdivision

1.11 2; 144.6502, subdivision 1; 144A.161, subdivision 1a; 144A.472, subdivision 5;

1.12 144A.72, subdivision 2; 144G.08, by adding subdivisions; 144G.19, by adding a

1.13 subdivision; 144G.31, subdivision 6; 157.17, subdivisions 2, 5; 182.6545; 245.095,

1.14 by adding a subdivision; 245.991, subdivision 3; 245.992, subdivision 2; 245A.02,

1.15 subdivision 5a; 245A.03, subdivision 7; 245D.081, subdivision 3; 245F.02,

1.16 subdivision 17; 245F.15, subdivision 7; 245G.04, by adding a subdivision; 245G.06,

1.17 subdivision 4; 245G.11, subdivision 8; 245I.04, by adding a subdivision; 245I.08,

1.18 subdivision 4; 245I.10, subdivision 6; 253B.03, subdivision 6; 253B.18, subdivision

1.19 14; 254B.052, subdivision 1, by adding a subdivision; 256.9752, as amended;

1.20 256B.04, subdivision 5; 256B.0624, subdivisions 6b, 7; 256B.0625, subdivision

1.21 47, by adding a subdivision; 256B.064, subdivisions 1b, 1c, 1d, 2, 3, 4, 5, by adding

1.22 subdivisions; 256B.0658; 256B.0759, subdivision 3; 256B.0911, subdivision 32;

1.23 256B.0924, subdivisions 3, 5, 7, by adding a subdivision; 256B.0943, subdivision

1.24 6; 256B.0946, subdivision 4; 256B.0947, subdivision 5; 256B.0949, subdivision

1.25 17, by adding a subdivision; 256B.4905, subdivision 2a; 256B.851, subdivision

1.26 8; 256L.03, subdivision 1; 256S.21, subdivision 3; 295.50, subdivision 4; 626.557,

1.27 subdivisions 9, 9a, 12b, by adding subdivisions; 626.5572, subdivisions 2, 9, 17,

1.28 by adding subdivisions; Minnesota Statutes 2025 Supplement, sections 13.46,

1.29 subdivision 2; 15.013, by adding a subdivision; 144A.474, subdivision 11;

1.30 144A.4799, subdivision 1; 245.469, subdivision 1; 245C.03, subdivision 6;

1.31 245C.10, subdivision 6; 245D.091, subdivisions 2, 3; 245F.08, subdivision 3;

1.32 245G.09, subdivision 3; 245G.11, subdivision 7; 245I.04, subdivision 17; 245I.23,

1.33 subdivision 7; 253B.18, subdivision 6; 254A.03, subdivision 3; 254B.04,

1.34 subdivision 1a; 254B.0501, subdivision 6; 254B.0505, subdivision 8, by adding

1.35 subdivisions; 256B.04, subdivision 21; 256B.0701, subdivision 9; 256B.0759,

1.36 subdivision 4; 256B.0911, subdivision 13; 256B.0924, subdivision 6; 256B.0943,

1.37 subdivision 1; 256B.0947, subdivision 3a; 256B.0949, subdivisions 2, 16, 18;

1.38 256B.4914, subdivisions 8, 10a; 256L.03, subdivision 5; 295.50, subdivision 9b;

2.1 626.5572, subdivision 13; Laws 2024, chapter 125, article 1, section 47; proposing
 2.2 coding for new law in Minnesota Statutes, chapters 144G; 246C; 256B; repealing
 2.3 Minnesota Statutes 2024, sections 256B.051, subdivisions 1, 4, 7; 256B.0759,
 2.4 subdivisions 2, 5; 256B.5012, subdivisions 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16;
 2.5 626.557, subdivision 10; Minnesota Statutes 2025 Supplement, sections 254B.052,
 2.6 subdivision 6; 256B.051, subdivisions 2, 3, 5, 6, 6a, 6b, 8, 9, 10.

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

2.8 **ARTICLE 1**

2.9 **DIRECT CARE AND TREATMENT POLICY**

2.10 Section 1. Minnesota Statutes 2024, section 3.7381, is amended to read:

2.11 **3.7381 LOSS, DAMAGE, OR DESTRUCTION OF PROPERTY; STATE**
 2.12 **INSTITUTIONS; CORRECTIONAL FACILITIES.**

2.13 (a) The commissioners of ~~human services~~, veterans affairs, or corrections or the Direct
 2.14 Care and Treatment executive board, as appropriate, shall determine, adjust, and settle, at
 2.15 any time, claims and demands of \$7,000 or less arising from negligent loss, damage, or
 2.16 destruction of property of a patient of a state institution under the control of the Direct Care
 2.17 and Treatment executive board or the commissioner of veterans affairs or an inmate of a
 2.18 state correctional facility.

2.19 (b) A claim of more than \$7,000, or a claim that was not paid by the appropriate
 2.20 department or agency may be presented to, heard, and determined by the appropriate
 2.21 committees of the senate and the house of representatives and, if approved, shall be paid
 2.22 pursuant to legislative claims procedure.

2.23 (c) The procedure established by this section is exclusive of all other legal, equitable,
 2.24 and statutory remedies.

2.25 Sec. 2. Minnesota Statutes 2024, section 13.04, subdivision 4a, is amended to read:

2.26 Subd. 4a. **Sex offender program data; challenges.** Notwithstanding subdivision 4,
 2.27 challenges to the accuracy or completeness of data maintained by the Direct Care and
 2.28 Treatment sex offender program about a civilly committed sex offender as defined in section
 2.29 246B.01, subdivision 1a, must be submitted in writing to the data practices compliance
 2.30 official of Direct Care and Treatment or a delegee. The data practices compliance official
 2.31 or a delegee must respond to the challenge as provided in this section.

2.32 Sec. 3. Minnesota Statutes 2024, section 13.384, subdivision 1, is amended to read:

2.33 Subdivision 1. ~~Definition~~ **Definitions.** As used in this section:

3.1 (a) "Directory information" means name of the patient, date admitted, and general
3.2 condition.

3.3 (b) "Medical data" are data collected because an individual was or is a patient or client
3.4 of a hospital, nursing home, medical center, clinic, health or nursing agency operated by a
3.5 government entity including business and financial records, data provided by private health
3.6 care facilities, and data provided by or about relatives of the individual. Medical data does
3.7 not include data collected, maintained, used, or disseminated by Direct Care and Treatment.

3.8 Sec. 4. Minnesota Statutes 2024, section 13.43, subdivision 5a, is amended to read:

3.9 Subd. 5a. **Limitation on disclosure of certain personnel data.** (a) Notwithstanding
3.10 any other provision of this section, the following data relating to employees of a secure
3.11 treatment facility as defined in section 253B.02, subdivision 18a, or 253D.02, subdivision
3.12 13; employees of a treatment program as defined in section 253D.02, subdivision 17;
3.13 employees of a state correctional facility; or employees of the Department of Corrections
3.14 directly involved in supervision of offenders in the community, ~~shall~~ must not be disclosed
3.15 to facility patients or clients, corrections inmates, or other individuals who facility or
3.16 correction administrators reasonably believe will use the information to harass, intimidate,
3.17 or assault any of these employees:

3.18 (1) place where previous education or training occurred;

3.19 (2) place of prior employment; and

3.20 (3) payroll timesheets or other comparable data, to the extent that disclosure of payroll
3.21 timesheets or other comparable data may disclose future work assignments, home address
3.22 or telephone number, the location of an employee during nonwork hours, or the location of
3.23 an employee's immediate family members.

3.24 (b) For employees of a secure treatment facility as defined in section 253B.02, subdivision
3.25 18a, or 253D.02, subdivision 13, or employees of a treatment program as defined in section
3.26 253D.02, subdivision 17, the final disposition of any disciplinary action together with the
3.27 specific reasons for the action and data documenting the basis of the action under subdivision
3.28 2, paragraph (a), clause (5), must not be disclosed to facility patients or clients, or other
3.29 individuals that Direct Care and Treatment reasonably believes will use the information to
3.30 harass, intimidate, or assault any of these employees.

3.31 (c) Notwithstanding section 13.05, subdivision 12, a government entity that receives a
3.32 request for personnel data that may be subject to paragraph (a) is authorized to require the
3.33 requesting person to identify themselves and state a reason for their request.

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

4.2 Sec. 5. Minnesota Statutes 2024, section 13.46, subdivision 1, is amended to read:

4.3 Subdivision 1. **Definitions.** As used in this section:

4.4 (a) "Individual" means an individual according to section 13.02, subdivision 8, but does
4.5 not include a vendor of services.

4.6 (b) "Program" includes all programs for which authority is vested in a component of the
4.7 welfare system according to statute or federal law, including but not limited to Native
4.8 American Tribe programs that provide a service component of the welfare system, the
4.9 Minnesota family investment program, medical assistance, general assistance, general
4.10 assistance medical care formerly codified in chapter 256D, the child care assistance program,
4.11 and child support collections.

4.12 (c) "Welfare system" includes the Department of Human Services; Direct Care and
4.13 Treatment; the Department of Children, Youth, and Families; local social services agencies;
4.14 county welfare agencies; county public health agencies; county veteran services agencies;
4.15 county housing agencies; private licensing agencies; the public authority responsible for
4.16 child support enforcement; human services boards; community mental health center boards,
4.17 state hospitals, state nursing homes, the ombudsman for mental health and developmental
4.18 disabilities; Native American Tribes to the extent a Tribe provides a service component of
4.19 the welfare system; and persons, agencies, institutions, organizations, and other entities
4.20 under contract to any of the above agencies to the extent specified in the contract.

4.21 (d) "Mental health data" means data on individual clients and patients of community
4.22 mental health centers, established under section 245.62, mental health divisions of counties
4.23 and other providers under contract to deliver mental health services, ~~Direct Care and~~
4.24 ~~Treatment mental health services~~, or the ombudsman for mental health and developmental
4.25 disabilities.

4.26 (e) "Fugitive felon" means a person who has been convicted of a felony and who has
4.27 escaped from confinement or violated the terms of probation or parole for that offense.

4.28 (f) "Private licensing agency" means an agency licensed by the commissioner of children,
4.29 youth, and families under chapter 142B to perform the duties under section 142B.30.

5.1 Sec. 6. Minnesota Statutes 2025 Supplement, section 13.46, subdivision 2, is amended to
5.2 read:

5.3 Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated
5.4 by the welfare system are private data on individuals, and shall not be disclosed except:

5.5 (1) according to section 13.05;

5.6 (2) according to court order;

5.7 (3) according to a statute specifically authorizing access to the private data;

5.8 (4) to an agent or investigator acting on behalf of a county, the state, or the federal
5.9 government, including a law enforcement person or attorney in the investigation or
5.10 prosecution of a criminal, civil, or administrative proceeding relating to the administration
5.11 of a program;

5.12 (5) to personnel of the welfare system who require the data to verify an individual's
5.13 identity; determine eligibility, amount of assistance, and the need to provide services to an
5.14 individual or family across programs; coordinate services for an individual or family;
5.15 evaluate the effectiveness of programs; assess parental contribution amounts; and investigate
5.16 suspected fraud;

5.17 (6) to administer federal funds or programs;

5.18 (7) between personnel of the welfare system working in the same program;

5.19 (8) to the Department of Revenue to administer and evaluate tax refund or tax credit
5.20 programs and to identify individuals who may benefit from these programs, and prepare
5.21 the databases for reports required under section 270C.13 and Laws 2008, chapter 366, article
5.22 17, section 6. The following information may be disclosed under this paragraph: an
5.23 individual's and their dependent's names, dates of birth, Social Security or individual taxpayer
5.24 identification numbers, income, addresses, and other data as required, upon request by the
5.25 Department of Revenue. Disclosures by the commissioner of revenue to the commissioner
5.26 of human services for the purposes described in this clause are governed by section 270B.14,
5.27 subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent
5.28 care credit under section 290.067, the Minnesota working family credit under section
5.29 290.0671, the property tax refund under section 290A.04, and the Minnesota education
5.30 credit under section 290.0674;

5.31 (9) between the Department of Human Services; the Department of Employment and
5.32 Economic Development; the Department of Children, Youth, and Families; Direct Care and
5.33 Treatment; and, when applicable, the Department of Education, for the following purposes:

6.1 (i) to monitor the eligibility of the data subject for unemployment benefits, for any
6.2 employment or training program administered, supervised, or certified by that agency;

6.3 (ii) to administer any rehabilitation program or child care assistance program, whether
6.4 alone or in conjunction with the welfare system;

6.5 (iii) to monitor and evaluate the Minnesota family investment program or the child care
6.6 assistance program by exchanging data on recipients and former recipients of Supplemental
6.7 Nutrition Assistance Program (SNAP) benefits, cash assistance under chapter 142F, 256D,
6.8 256J, or 256K, child care assistance under chapter 142E, medical programs under chapter
6.9 256B or 256L; and

6.10 (iv) to analyze public assistance employment services and program utilization, cost,
6.11 effectiveness, and outcomes as implemented under the authority established in Title II,
6.12 Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999.
6.13 Health records governed by sections 144.291 to 144.298 and "protected health information"
6.14 as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code
6.15 of Federal Regulations, title 45, parts 160-164, including health care claims utilization
6.16 information, must not be exchanged under this clause;

6.17 (10) to appropriate parties in connection with an emergency if knowledge of the
6.18 information is necessary to protect the health or safety of the individual or other individuals
6.19 or persons;

6.20 (11) data maintained by residential programs as defined in section 245A.02 may be
6.21 disclosed to the protection and advocacy system established in this state according to Part
6.22 C of Public Law 98-527 to protect the legal and human rights of persons with developmental
6.23 disabilities or other related conditions who live in residential facilities for these persons if
6.24 the protection and advocacy system receives a complaint by or on behalf of that person and
6.25 the person does not have a legal guardian or the state or a designee of the state is the legal
6.26 guardian of the person;

6.27 (12) to the county medical examiner or the county coroner for identifying or locating
6.28 relatives or friends of a deceased person;

6.29 (13) data on a child support obligor who makes payments to the public agency may be
6.30 disclosed to the Minnesota Office of Higher Education to the extent necessary to determine
6.31 eligibility under section 136A.121, subdivision 2, clause (5);

6.32 (14) participant Social Security or individual taxpayer identification numbers and names
6.33 collected by the telephone assistance program may be disclosed to the Department of

7.1 Revenue to conduct an electronic data match with the property tax refund database to
7.2 determine eligibility under section 237.70, subdivision 4a;

7.3 (15) the current address of a Minnesota family investment program participant may be
7.4 disclosed to law enforcement officers who provide the name of the participant and notify
7.5 the agency that:

7.6 (i) the participant:

7.7 (A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after
7.8 conviction, for a crime or attempt to commit a crime that is a felony under the laws of the
7.9 jurisdiction from which the individual is fleeing; or

7.10 (B) is violating a condition of probation or parole imposed under state or federal law;

7.11 (ii) the location or apprehension of the felon is within the law enforcement officer's
7.12 official duties; and

7.13 (iii) the request is made in writing and in the proper exercise of those duties;

7.14 (16) the current address of a recipient of general assistance may be disclosed to probation
7.15 officers and corrections agents who are supervising the recipient and to law enforcement
7.16 officers who are investigating the recipient in connection with a felony level offense;

7.17 (17) information obtained from a SNAP applicant or recipient households may be
7.18 disclosed to local, state, or federal law enforcement officials, upon their written request, for
7.19 the purpose of investigating an alleged violation of the Food and Nutrition Act, according
7.20 to Code of Federal Regulations, title 7, section 272.1(c);

7.21 (18) the address, Social Security or individual taxpayer identification number, and, if
7.22 available, photograph of any member of a household receiving SNAP benefits shall be made
7.23 available, on request, to a local, state, or federal law enforcement officer if the officer
7.24 furnishes the agency with the name of the member and notifies the agency that:

7.25 (i) the member:

7.26 (A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a
7.27 crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

7.28 (B) is violating a condition of probation or parole imposed under state or federal law;
7.29 or

7.30 (C) has information that is necessary for the officer to conduct an official duty related
7.31 to conduct described in subitem (A) or (B);

8.1 (ii) locating or apprehending the member is within the officer's official duties; and

8.2 (iii) the request is made in writing and in the proper exercise of the officer's official duty;

8.3 (19) the current address of a recipient of Minnesota family investment program, general
8.4 assistance, or SNAP benefits may be disclosed to law enforcement officers who, in writing,
8.5 provide the name of the recipient and notify the agency that the recipient is a person required
8.6 to register under section 243.166, but is not residing at the address at which the recipient is
8.7 registered under section 243.166;

8.8 (20) certain information regarding child support obligors who are in arrears may be
8.9 made public according to section 518A.74;

8.10 (21) data on child support payments made by a child support obligor and data on the
8.11 distribution of those payments excluding identifying information on obligees may be
8.12 disclosed to all obligees to whom the obligor owes support, and data on the enforcement
8.13 actions undertaken by the public authority, the status of those actions, and data on the income
8.14 of the obligor or obligee may be disclosed to the other party;

8.15 (22) data in the work reporting system may be disclosed under section 142A.29,
8.16 subdivision 7;

8.17 (23) to the Department of Education for the purpose of matching Department of Education
8.18 student data with public assistance data to determine students eligible for free and
8.19 reduced-price meals, meal supplements, and free milk according to United States Code,
8.20 title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state
8.21 funds that are distributed based on income of the student's family; and to verify receipt of
8.22 energy assistance for the telephone assistance plan;

8.23 (24) the current address and telephone number of program recipients and emergency
8.24 contacts may be released to the commissioner of health or a community health board as
8.25 defined in section 145A.02, subdivision 5, when the commissioner or community health
8.26 board has reason to believe that a program recipient is a disease case, carrier, suspect case,
8.27 or at risk of illness, and the data are necessary to locate the person;

8.28 (25) to other state agencies, statewide systems, and political subdivisions of this state,
8.29 including the attorney general, and agencies of other states, interstate information networks,
8.30 federal agencies, and other entities as required by federal regulation or law for the
8.31 administration of the child support enforcement program;

9.1 (26) to personnel of public assistance programs as defined in section 518A.81, for access
9.2 to the child support system database for the purpose of administration, including monitoring
9.3 and evaluation of those public assistance programs;

9.4 (27) to monitor and evaluate the Minnesota family investment program by exchanging
9.5 data between the Departments of Human Services; Children, Youth, and Families; and
9.6 Education, on recipients and former recipients of SNAP benefits, cash assistance under
9.7 chapter 142F, 256D, 256J, or 256K, child care assistance under chapter 142E, medical
9.8 programs under chapter 256B or 256L, or a medical program formerly codified under chapter
9.9 256D;

9.10 (28) to evaluate child support program performance and to identify and prevent fraud
9.11 in the child support program by exchanging data between the Department of Human Services;
9.12 Department of Children, Youth, and Families; Department of Revenue under section 270B.14,
9.13 subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph
9.14 (c); Department of Health; Department of Employment and Economic Development; and
9.15 other state agencies as is reasonably necessary to perform these functions;

9.16 (29) counties and the Department of Children, Youth, and Families operating child care
9.17 assistance programs under chapter 142E may disseminate data on program participants,
9.18 applicants, and providers to the commissioner of education;

9.19 (30) child support data on the child, the parents, and relatives of the child may be
9.20 disclosed to agencies administering programs under titles IV-B and IV-E of the Social
9.21 Security Act, as authorized by federal law;

9.22 (31) to a health care provider governed by sections 144.291 to 144.298, to the extent
9.23 necessary to coordinate services;

9.24 (32) to the chief administrative officer of a school to coordinate services for a student
9.25 and family; data that may be disclosed under this clause are limited to name, date of birth,
9.26 gender, and address;

9.27 (33) to county correctional agencies to the extent necessary to coordinate services and
9.28 diversion programs; data that may be disclosed under this clause are limited to name, client
9.29 demographics, program, case status, and county worker information; or

9.30 (34) between the Department of Human Services and the Metropolitan Council for the
9.31 following purposes:

10.1 (i) to coordinate special transportation service provided under section 473.386 with
10.2 services for people with disabilities and elderly individuals funded by or through the
10.3 Department of Human Services; and

10.4 (ii) to provide for reimbursement of special transportation service provided under section
10.5 473.386.

10.6 The data that may be shared under this clause are limited to the individual's first, last, and
10.7 middle names; date of birth; residential address; and program eligibility status with expiration
10.8 date for the purposes of informing the other party of program eligibility.

10.9 (b) Information on persons who have been treated for substance use disorder may only
10.10 be disclosed according to the requirements of Code of Federal Regulations, title 42, sections
10.11 2.1 to 2.67.

10.12 (c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16),
10.13 (17), or (18), or paragraph (b), are investigative data and are confidential or protected
10.14 nonpublic while the investigation is active. The data are private after the investigation
10.15 becomes inactive under section 13.82, subdivision 7, clause (a) or (b).

10.16 (d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are
10.17 not subject to the access provisions of subdivision 10, paragraph (b).

10.18 (e) For the purposes of this subdivision, a request ~~will be~~ is deemed to be made in writing
10.19 if made through a computer interface system.

10.20 (f) Direct Care and Treatment may disclose data pursuant to this subdivision regardless
10.21 of any restrictions on disclosure of that data under sections 144.291 to 144.298.

10.22 (g) Notwithstanding section 144.2925, Direct Care and Treatment may disclose data as
10.23 permitted by law.

10.24 (h) Direct Care and Treatment is not required to share with federal law enforcement data
10.25 on individuals collected, maintained, used, or disseminated by Direct Care and Treatment
10.26 that relate to the reporting of suspected crime unless specifically required to do so by a
10.27 Minnesota or federal law.

10.28 (i) Direct Care and Treatment may disclose welfare system data held by the agency to
10.29 facilitate coordination of guardianship services for Direct Care and Treatment clients,
10.30 including but not limited to making disclosures in guardianship proceedings, identifying
10.31 potential guardians, communicating with guardianship legal representation, and reporting
10.32 complaints to the judicial branch or the Office of Ombudsman for Mental Health and

11.1 Developmental Disabilities. Direct Care and Treatment must obtain the client's consent to
 11.2 the disclosure except when the client:

11.3 (1) lacks capacity to provide the consent; or

11.4 (2) has a current legal guardian who is unavailable, is nonresponsive, or refuses to
 11.5 authorize the disclosure in relation to complaints to the judicial branch or Office of
 11.6 Ombudsman for Mental Health and Developmental Disabilities.

11.7 Sec. 7. Minnesota Statutes 2024, section 182.6545, is amended to read:

11.8 **182.6545 RIGHTS OF NEXT OF KIN UPON DEATH.**

11.9 In the case of a death of an employee, the department shall make reasonable efforts to
 11.10 locate the employee's next of kin and shall mail to them copies of the following:

11.11 (1) citations and notification of penalty;

11.12 (2) notices of hearings;

11.13 (3) complaints and answers;

11.14 (4) settlement agreements;

11.15 (5) orders and decisions; and

11.16 (6) notices of appeals.

11.17 In addition, the next of kin shall have the right to request a consultation with the
 11.18 department regarding citations and notification of penalties issued as a result of the
 11.19 investigation of the employee's death. For the purposes of this section, "next of kin" refers
 11.20 to the nearest proper relative as that term is defined by section 253B.03, subdivision 6,
 11.21 paragraph (b), clause ~~(3)~~ (10).

11.22 **Sec. 8. [246C.051] CLASSIFICATION ALIGNMENT FOR DIRECT CARE AND**
 11.23 **TREATMENT EMPLOYEES.**

11.24 (a) Notwithstanding section 43A.08; Minnesota Rules, part 3900.1300; or any other law
 11.25 to the contrary, Direct Care and Treatment may, with approval from Minnesota Management
 11.26 and Budget, convert employees deemed unclassified pursuant to pilot authority of the
 11.27 Department of Human Services under Laws 1997, chapter 97, section 18, into the classified
 11.28 service.

11.29 (b) Employees converted to the classified service pursuant to this section are subject to
 11.30 the terms and conditions of employment applicable to positions in the classified service

12.1 pursuant to statute, rule, bargaining unit or compensation plan, and agency policy, including
 12.2 but not limited to required probationary periods and mandatory training requirements.

12.3 (c) Employees converted to the classified service pursuant to this section must not receive
 12.4 a reduction in salary at the time of the conversion.

12.5 Sec. 9. Minnesota Statutes 2024, section 253B.03, subdivision 6, is amended to read:

12.6 Subd. 6. **Consent for medical procedure.** (a) A patient has the right to give prior consent
 12.7 to any medical ~~or surgical~~ treatment, including but not limited to surgery, other than treatment
 12.8 for chemical dependency or nonintrusive treatment for mental illness. For purposes of this
 12.9 subdivision, "patient" includes a person committed under chapter 253D who is in a
 12.10 state-operated treatment program.

12.11 (b) The following procedures shall be used to obtain consent for any treatment necessary
 12.12 to preserve the life or health of any committed patient:

12.13 (1) the written, informed consent of a competent adult patient for the treatment is
 12.14 sufficient;

12.15 (2) if the patient is subject to guardianship which includes the provision of medical care,
 12.16 the written, informed consent of the guardian for the treatment is sufficient;

12.17 (3) for a patient in a treatment facility, if the head of the treatment facility ~~or~~
 12.18 ~~state-operated treatment program~~ determines that the patient is not competent to consent to
 12.19 the treatment and the patient has not been adjudicated incompetent, written, informed consent
 12.20 for the ~~surgery~~ or medical treatment shall be obtained from the person appointed the health
 12.21 care power of attorney, the patient's agent under the health care directive, or the nearest
 12.22 proper relative. ~~For this purpose, the following persons are proper relatives, in the order~~
 12.23 ~~listed: the patient's spouse, parent, adult child, or adult sibling.~~ If the nearest proper relatives
 12.24 relative cannot be located, refuse refuses to consent to the procedure, or ~~are~~ is unable to
 12.25 consent, the head of the treatment facility ~~or state-operated treatment program~~ or an interested
 12.26 person, as defined by section 524.5-102, subdivision 7, may petition the committing court
 12.27 for approval for the treatment or may petition a court of competent jurisdiction for the
 12.28 appointment of a guardian. The determination that the patient is not competent, and the
 12.29 reasons for the determination, shall be documented in the patient's clinical record;

12.30 (4) for patients in a state-operated treatment program, if (i) the patient does not have a
 12.31 health care power of attorney or an agent under a health care directive or the patient's health
 12.32 care agent is not reasonably available to make the necessary health care decision for the
 12.33 patient, and (ii) the patient's treating physician determines that the patient lacks

13.1 decision-making capacity to consent to the medical treatment, the state-operated treatment
13.2 program must make a good faith attempt to locate the patient's nearest proper relative to
13.3 obtain written informed consent for the medical treatment;

13.4 (5) if the state-operated treatment program is unable to reasonably locate a proper relative,
13.5 the executive medical director has decision-making authority for the health care decision
13.6 for the patient;

13.7 (6) any health care decision made by the executive medical director under clause (5)
13.8 must be consistent with any documented patient health care directive and with reasonable
13.9 medical practice and applicable law;

13.10 (7) if the state-operated treatment program consults with the patient's nearest proper
13.11 relative under clause (4) and the patient's nearest proper relative and the patient's treating
13.12 physician are not in agreement with respect to a medical treatment decision, the state-operated
13.13 treatment program or an interested person may petition the committing court for approval
13.14 of the treatment. The state-operated treatment program may also petition a court of competent
13.15 jurisdiction for the appointment of a guardian at any time. If a court determines that a patient
13.16 is not competent, the determination and the reasons for the determination must be documented
13.17 in the patient's clinical record;

13.18 (8) before proceeding with treatment under clause (5), a state-operated treatment program
13.19 must inform the patient of the determination, the proposed treatment, and the right to request
13.20 review. Upon the request of the patient or an interested person, a second physician not
13.21 directly involved in the patient's current treatment must review the incapacity determination.
13.22 The executive medical director must review the proposed treatment decision and the second
13.23 physician's review and make an updated determination. A state-operated treatment program
13.24 may proceed with treatment of the patient while a review under this clause is pending;

13.25 (9) if a patient or interested person is dissatisfied with the outcome of the review under
13.26 clause (8), the patient or interested person may petition the committing court under section
13.27 253B.17 for review of the determination made under clause (8). Filing a petition under
13.28 section 253B.17 does not stay treatment under this subdivision unless otherwise ordered by
13.29 the court. In reviewing the executive medical director's decision under clause (8) and issuing
13.30 a determination, the court must determine if the patient lacks capacity. If the patient lacks
13.31 capacity, the court must determine if the patient clearly stated what the patient would choose
13.32 to do in the situation when the patient had the capacity to make a reasoned decision. Evidence
13.33 of the patient's wishes may include written instruments, including a durable power of attorney
13.34 for health care under chapter 145C or a declaration under subdivision 6d. If the court finds

14.1 that the patient clearly stated what the patient would choose to do in the situation, the patient's
14.2 wishes must be followed. If the court determines that the evidence of the patient's wishes
14.3 regarding the situation is conflicting or lacking, the court must make a decision based on
14.4 what a reasonable person would do, taking into consideration:

14.5 (i) the patient's family, community, moral, religious, and social values;

14.6 (ii) the medical risks, benefits, and alternatives to the proposed treatment;

14.7 (iii) past efficacy and any extenuating circumstances of past experience with the particular
14.8 medical treatment; and

14.9 (iv) any other relevant factors;

14.10 (10) for purposes of this subdivision, the following persons are proper relatives, in the
14.11 order listed: the patient's spouse, parent, adult child, or adult sibling;

14.12 ~~(4)~~ (11) consent to treatment of any minor patient shall be secured in accordance with
14.13 sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization,
14.14 routine diagnostic evaluation, and emergency or short-term acute care; and

14.15 ~~(5)~~ (12) in the case of an emergency when the persons ordinarily qualified to give consent
14.16 cannot be located in sufficient time to address the emergency need, the head of the treatment
14.17 facility or state-operated treatment program may give consent.

14.18 (c) No person who consents to treatment pursuant to the provisions of this subdivision
14.19 shall be civilly or criminally liable for the performance or the manner of performing the
14.20 treatment. No person shall be liable for performing treatment without consent if written,
14.21 informed consent was given pursuant to this subdivision. This provision shall not affect any
14.22 other liability which may result from the manner in which the treatment is performed.

14.23 (d) When a determination is made under paragraph (b), clauses (5) and (8), the
14.24 state-operated treatment program must document the following information in the patient's
14.25 clinical record:

14.26 (1) the determination of incapacity and the clinical basis for the determination;

14.27 (2) the specific treatment authorized;

14.28 (3) the person who provided consent or who made the determination allowing the
14.29 treatment;

14.30 (4) the efforts made to locate and consult with a health care agent or nearest proper
14.31 relative; and

15.1 (5) the patient's expressed preferences regarding the treatment, if known, and how the
15.2 preferences were considered.

15.3 (e) The executive medical director must review a determination that a patient lacks
15.4 capacity periodically as medically appropriate, but not less than every six months. The
15.5 outcome of a review under this paragraph must be documented in the patient's clinical
15.6 record.

15.7 Sec. 10. Minnesota Statutes 2025 Supplement, section 253B.18, subdivision 6, is amended
15.8 to read:

15.9 Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is
15.10 dangerous to the public shall not be transferred out of a secure treatment facility unless it
15.11 appears to the satisfaction of the executive board, after a hearing and favorable
15.12 recommendation by a majority of the special review board, that the transfer is appropriate.
15.13 Transfer may be to another state-operated treatment program. In those instances where a
15.14 commitment also exists to the Department of Corrections, transfer may be to a facility
15.15 designated by the commissioner of corrections.

15.16 (b) The following factors must be considered in determining whether a transfer is
15.17 appropriate:

15.18 (1) the person's clinical progress and present treatment needs;

15.19 (2) the need for security to accomplish continuing treatment;

15.20 (3) the need for continued institutionalization;

15.21 (4) which facility can best meet the person's needs; and

15.22 (5) whether transfer can be accomplished with a reasonable degree of safety for the
15.23 public.

15.24 (c) If a committed person has been transferred out of a secure treatment facility pursuant
15.25 to this subdivision, that committed person may voluntarily return to a secure treatment
15.26 facility ~~for a period of up to 60 days~~ with the consent of the head of the treatment facility:
15.27 for a period of up to:

15.28 (1) 90 days if due to a psychiatric medical condition; or

15.29 (2) six months if due to a nonpsychiatric medical condition.

15.30 (d) If the committed person is not returned to the original, nonsecure transfer facility
15.31 within ~~60~~ 90 days of being readmitted to a secure treatment facility if due to a psychiatric

16.1 medical condition or within six months of being readmitted to a secure treatment facility if
16.2 due to a nonpsychiatric medical condition, the transfer is revoked and the committed person
16.3 must remain in a secure treatment facility. The committed person must immediately be
16.4 notified in writing of the revocation.

16.5 (e) Within 15 days of receiving notice of the revocation, the committed person may
16.6 petition the special review board for a review of the revocation. The special review board
16.7 shall review the circumstances of the revocation and shall recommend to the executive
16.8 board whether or not the revocation should be upheld. The special review board may also
16.9 recommend a new transfer at the time of the revocation hearing.

16.10 (f) No action by the special review board is required if the transfer has not been revoked
16.11 and the committed person is returned to the original, nonsecure transfer facility with no
16.12 substantive change to the conditions of the transfer ordered under this subdivision.

16.13 (g) The head of the treatment facility may revoke a transfer made under this subdivision
16.14 and require a committed person to return to a secure treatment facility if:

16.15 (1) remaining in a nonsecure setting does not provide a reasonable degree of safety to
16.16 the committed person or others; or

16.17 (2) the committed person has regressed clinically and the facility to which the committed
16.18 person was transferred does not meet the committed person's needs.

16.19 (h) Upon the revocation of the transfer, the committed person must be immediately
16.20 returned to a secure treatment facility. A report documenting the reasons for revocation
16.21 must be issued by the head of the treatment facility within seven days after the committed
16.22 person is returned to the secure treatment facility. Advance notice to the committed person
16.23 of the revocation is not required.

16.24 (i) The committed person must be provided a copy of the revocation report and informed,
16.25 orally and in writing, of the rights of a committed person under this section. The revocation
16.26 report must be served upon the committed person, the committed person's counsel, and the
16.27 designated agency. The report must outline the specific reasons for the revocation, including
16.28 but not limited to the specific facts upon which the revocation is based.

16.29 (j) If a committed person's transfer is revoked, the committed person may re-petition for
16.30 transfer according to subdivision 5.

16.31 (k) A committed person aggrieved by a transfer revocation decision may petition the
16.32 special review board within seven business days after receipt of the revocation report for a
16.33 review of the revocation. The matter must be scheduled within 30 days. The special review

17.1 board shall review the circumstances leading to the revocation and, after considering the
 17.2 factors in paragraph (b), shall recommend to the executive board whether or not the
 17.3 revocation shall be upheld. The special review board may also recommend a new transfer
 17.4 out of a secure treatment facility at the time of the revocation hearing.

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

17.6 Sec. 11. Minnesota Statutes 2024, section 253B.18, subdivision 14, is amended to read:

17.7 Subd. 14. **Voluntary readmission.** (a) With the consent of the head of the treatment
 17.8 facility or state-operated treatment program, a patient may voluntarily return from provisional
 17.9 discharge with the consent of the designated agency for a period of up to:

17.10 (1) 30 days; or;

17.11 (2) up to 60 90 days with the consent of the designated agency. if due to a psychiatric
 17.12 medical condition; or

17.13 (3) six months if due to a nonpsychiatric medical condition.

17.14 (b) If the patient is not returned to provisional discharge status within 60 90 days of
 17.15 being readmitted if due to a psychiatric medical condition or within six months of being
 17.16 readmitted if due to a nonpsychiatric medical condition, the provisional discharge is revoked.
 17.17 Within 15 days of receiving notice of the change in status, the patient may request a review
 17.18 of the matter before the special review board. The special review board may recommend a
 17.19 return to a provisional discharge status.

17.20 ~~(b)~~ (c) The treatment facility or state-operated treatment program is not required to
 17.21 petition for a further review by the special review board unless the patient's return to the
 17.22 community results in substantive change to the existing provisional discharge plan. All the
 17.23 terms and conditions of the provisional discharge order shall remain unchanged if the patient
 17.24 is released again.

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

17.26 **ARTICLE 2**

17.27 **DEPARTMENT OF HEALTH POLICY**

17.28 Section 1. Minnesota Statutes 2024, section 144.56, subdivision 2b, is amended to read:

17.29 Subd. 2b. **Boarding care homes.** The commissioner shall not adopt or enforce any rule
 17.30 that limits:

18.1 (1) a certified boarding care home from providing nursing services in accordance with
18.2 the home's Medicaid certification; or

18.3 (2) a noncertified boarding care home ~~registered under chapter 144D~~ from providing
18.4 home care services ~~in accordance with the home's registration.~~

18.5 Sec. 2. Minnesota Statutes 2024, section 144.586, subdivision 2, is amended to read:

18.6 Subd. 2. **Postacute care discharge planning.** (a) Each hospital, including hospitals
18.7 designated as critical access hospitals, must comply with the federal hospital requirements
18.8 for discharge planning₂, which include:

18.9 (1) conducting a discharge planning evaluation that includes an evaluation of:

18.10 (i) the likelihood of the patient needing posthospital services and of the availability of
18.11 those services; and

18.12 (ii) the patient's capacity for self-care or the possibility of the patient being cared for in
18.13 the environment from which the patient entered the hospital;

18.14 (2) timely completion of the discharge planning evaluation under clause (1) by hospital
18.15 personnel so that appropriate arrangements for posthospital care are made before discharge,
18.16 and to avoid unnecessary delays in discharge;

18.17 (3) including the discharge planning evaluation under clause (1) in the patient's medical
18.18 record for use in establishing an appropriate discharge plan. The hospital must discuss the
18.19 results of the evaluation with the patient or individual acting on behalf of the patient. The
18.20 hospital must reassess the patient's discharge plan if the hospital determines that there are
18.21 factors that may affect continuing care needs or the appropriateness of the discharge plan;
18.22 and

18.23 (4) providing counseling, as needed, for the patient and family members or interested
18.24 persons to prepare them for posthospital care. The hospital must provide a list of available
18.25 Medicare-eligible home care agencies or skilled nursing facilities that serve the patient's
18.26 geographic area, or other area requested by the patient if such care or placement is indicated
18.27 and appropriate. Once the patient has designated their preferred providers, the hospital will
18.28 assist the patient in securing care covered by their health plan or within the care network.
18.29 The hospital must not specify or otherwise limit the qualified providers that are available
18.30 to the patient. The hospital must document in the patient's record that the list was presented
18.31 to the patient or to the individual acting on the patient's behalf.

19.1 (b) Each hospital, including hospitals designated as critical access hospitals, must
 19.2 document in the patient's discharge plan instances when a restraint was used to manage the
 19.3 patient's behavior prior to discharge, including the type of restraint, duration, and frequency.
 19.4 In cases where the patient is transferred to a licensed or registered provider, the hospital
 19.5 must notify the provider of the type, duration, and frequency of the restraint. "Restraint"
 19.6 has the meaning given in section 144G.08, subdivision 61a.

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

19.8 Sec. 3. Minnesota Statutes 2024, section 144.6502, subdivision 1, is amended to read:

19.9 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this
 19.10 subdivision have the meanings given.

19.11 (b) "Commissioner" means the commissioner of health.

19.12 (c) "Department" means the Department of Health.

19.13 (d) "Electronic monitoring" means the placement and use of an electronic monitoring
 19.14 device in the resident's room or private living unit in accordance with this section.

19.15 (e) "Electronic monitoring device" means a camera or other device that captures, records,
 19.16 or broadcasts audio, video, or both, that is placed in a resident's room or private living unit
 19.17 and is used to monitor the resident or activities in the room or private living unit.

19.18 (f) "Facility" means a facility that is:

19.19 (1) licensed as a nursing home under chapter 144A;

19.20 (2) licensed as a boarding care home under sections 144.50 to 144.56; or

19.21 ~~(3) until August 1, 2021, a housing with services establishment registered under chapter~~
 19.22 ~~144D that is either subject to chapter 144G or has a disclosed special unit under section~~
 19.23 ~~325F.72; or~~

19.24 ~~(4) on or after August 1, 2021, (3) licensed as an assisted living facility under chapter~~
 19.25 144G.

19.26 (g) "Resident" means a person 18 years of age or older residing in a facility.

19.27 (h) "Resident representative" means one of the following in the order of priority listed,
 19.28 to the extent the person may reasonably be identified and located:

19.29 (1) a court-appointed guardian;

19.30 (2) a health care agent as defined in section 145C.01, subdivision 2; or

20.1 (3) a person who is not an agent of a facility or of a home care provider designated in
20.2 writing by the resident and maintained in the resident's records on file with the facility.

20.3 Sec. 4. Minnesota Statutes 2024, section 144A.161, subdivision 1a, is amended to read:

20.4 Subd. 1a. **Scope.** Where a facility is undertaking a closure, reduction, or change in
20.5 operations, ~~or where a housing with services unit registered under chapter 144D is closed~~
20.6 ~~because the space that it occupies is being replaced by a nursing facility bed that is being~~
20.7 ~~reactivated from layaway status,~~ the facility and the county social services agency must
20.8 comply with the requirements of this section.

20.9 Sec. 5. Minnesota Statutes 2024, section 144A.472, subdivision 5, is amended to read:

20.10 Subd. 5. **Changes in ownership.** (a) A home care license issued by the commissioner
20.11 may not be transferred to another party. Before acquiring ownership of or a controlling
20.12 interest in a home care provider business, a prospective owner must apply for a new license.
20.13 A change of ownership is a transfer of operational control of the home care provider business
20.14 and includes:

20.15 (1) transfer of the business to a different or new corporation;

20.16 (2) in the case of a partnership, the dissolution or termination of the partnership under
20.17 chapter 323A, with the business continuing by a successor partnership or other entity;

20.18 (3) relinquishment of control of the provider to another party, including to a contract
20.19 management firm that is not under the control of the owner of the business' assets;

20.20 (4) transfer of the business by a sole proprietor to another party or entity; or

20.21 (5) transfer of ownership or control of 50 percent or more of the controlling interest of
20.22 a home care provider business not covered by clauses (1) to (4).

20.23 (b) An employee who was employed by the previous owner of the home care provider
20.24 business prior to the effective date of a change in ownership under paragraph (a), and who
20.25 will be employed by the new owner in the same or a similar capacity, shall be treated as if
20.26 no change in employer occurred, with respect to orientation, training, tuberculosis testing,
20.27 background studies, and competency testing and training on the policies identified in
20.28 subdivision 1, clause (14), and subdivision 2, if applicable.

20.29 (c) Notwithstanding paragraph (b), a new owner of a home care provider business must
20.30 ensure that employees of the provider receive and complete training and testing on any

21.1 provisions of policies that differ from those of the previous owner within 90 days after the
21.2 date of the change in ownership.

21.3 (d) After a change of ownership, the new licensee is responsible for any outstanding
21.4 finances and any fines assessed following the effective date of the change of ownership.
21.5 Additionally, the new licensee is responsible for bringing the home care provider into
21.6 compliance with all existing ordered, imposed, or agreed-upon corrections and conditions.

21.7 Sec. 6. Minnesota Statutes 2025 Supplement, section 144A.474, subdivision 11, is amended
21.8 to read:

21.9 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed
21.10 based on the level and scope of the violations described in paragraph (b) and imposed
21.11 immediately with no opportunity to correct the violation first as follows:

21.12 (1) Level 1, no fines or enforcement;

21.13 (2) Level 2, a fine of \$500 per violation, in addition to any of the enforcement
21.14 mechanisms authorized in section 144A.475;

21.15 (3) Level 3, a fine of \$1,000 per incident, in addition to any of the enforcement
21.16 mechanisms authorized in section 144A.475;

21.17 (4) Level 4, a fine of \$3,000 per incident, in addition to any of the enforcement
21.18 mechanisms authorized in section 144A.475;

21.19 (5) Level 5, a fine of \$5,000 per violation, in addition to any enforcement mechanism
21.20 authorized in section 144A.475; and

21.21 (6) for maltreatment violations for which the licensee was determined to be responsible
21.22 for the maltreatment under section 626.557, subdivision 9c, paragraph (c), a fine of \$1,000.
21.23 A fine of \$5,000 may be imposed if the commissioner determines the licensee is responsible
21.24 for maltreatment consisting of sexual assault, death, or abuse resulting in serious injury.

21.25 The fines in clauses (1) to (5) are increased and immediate fine imposition is authorized
21.26 for both surveys and investigations conducted.

21.27 When a fine is assessed against a facility for substantiated maltreatment, the commissioner
21.28 shall not also impose an immediate fine under this chapter for the same circumstance.

21.29 (b) Correction orders for violations are categorized by both level and scope and fines
21.30 shall be assessed as follows:

21.31 (1) level of violation:

22.1 (i) Level 1 is a violation that will cause only minimal impact on the client and does not
22.2 affect health or safety;

22.3 (ii) Level 2 is a violation that did not harm a client's health or safety but had the potential
22.4 to have harmed a client's health or safety, but was not likely to cause serious injury,
22.5 impairment, or death;

22.6 (iii) Level 3 is a violation that harmed a client's health or safety, or a violation that had
22.7 the potential to cause more than minimal harm to the client;

22.8 (iv) Level 4 is a violation that harmed a client's health or safety, not including serious
22.9 injury or death, or a violation that was likely to lead to serious injury or death; and

22.10 (v) Level 5 is a violation that results in serious injury or death; and

22.11 (2) scope of violation:

22.12 (i) isolated, when one or a limited number of clients are affected or one or a limited
22.13 number of staff are involved or the situation has occurred only occasionally;

22.14 (ii) pattern, when more than a limited number of clients are affected, more than a limited
22.15 number of staff are involved, or the situation has occurred repeatedly but is not found to be
22.16 pervasive; and

22.17 (iii) widespread, when problems are pervasive or represent a systemic failure that has
22.18 affected or has the potential to affect a large portion or all of the clients.

22.19 (c) If the commissioner finds that the applicant or a home care provider has not corrected
22.20 violations by the date specified in the correction order or conditional license resulting from
22.21 a survey or complaint investigation, the commissioner shall provide a notice of
22.22 noncompliance with a correction order by email to the applicant's or provider's last known
22.23 email address. The noncompliance notice must list the violations not corrected.

22.24 (d) For every violation identified by the commissioner, the commissioner shall issue an
22.25 immediate fine pursuant to paragraph (a). The license holder must still correct the violation
22.26 in the time specified. The issuance of an immediate fine can occur in addition to any
22.27 enforcement mechanism authorized under section 144A.475. The immediate fine may be
22.28 appealed as allowed under this subdivision.

22.29 (e) The license holder must pay the fines assessed on or before the payment date specified.
22.30 If the license holder fails to fully comply with the order, the commissioner may issue a
22.31 second fine or suspend the license until the license holder complies by paying the fine. A
22.32 timely appeal shall stay payment of the fine until the commissioner issues a final order.

23.1 (f) A license holder shall promptly notify the commissioner in writing when a violation
23.2 specified in the order is corrected. If upon reinspection the commissioner determines that
23.3 a violation has not been corrected as indicated by the order, the commissioner may issue a
23.4 second fine. The commissioner shall notify the license holder by mail to the last known
23.5 address in the licensing record that a second fine has been assessed. The license holder may
23.6 appeal the second fine as provided under this subdivision.

23.7 (g) A home care provider that has been assessed a fine under this subdivision has a right
23.8 to a reconsideration or a hearing under this section and chapter 14.

23.9 (h) When a fine has been assessed, the license holder may not avoid payment by closing,
23.10 ~~selling, or otherwise transferring the licensed program to a third party~~ the license. In such
23.11 an event, the license holder shall be liable for payment of the fine. In the event of a change
23.12 of ownership, the new licensee is responsible for any outstanding fines and any fines assessed
23.13 following the effective date of the change of ownership regardless of the date of the violation.

23.14 (i) In addition to any fine imposed under this section, the commissioner may assess a
23.15 penalty amount based on costs related to an investigation that results in a final order assessing
23.16 a fine or other enforcement action authorized by this chapter.

23.17 (j) Fines collected under paragraph (a) shall be deposited in a dedicated special revenue
23.18 account. ~~On an annual basis, the balance in the special revenue account shall be appropriated~~
23.19 ~~to the commissioner to implement the recommendations of the advisory council established~~
23.20 ~~in section 144A.4799.~~ Money deposited in the account is appropriated to the commissioner
23.21 on an annual basis for a competitive grant program for special projects for improving home
23.22 care client quality of care and outcomes in Minnesota, with a specific focus on workforce
23.23 and clinical outcomes, including projects consistent with the criteria in section 144A.4799,
23.24 subdivision 3, paragraph (c). Grants must be distributed to home care providers licensed
23.25 under this chapter or organizations with experience in or knowledge of home care operations,
23.26 compliance, client needs, or best practices. Each grant must be at least \$1,000. A provider
23.27 with a temporary license under this chapter is not eligible to apply for a grant. The
23.28 commissioner may retain up to ten percent of the amount available to cover the costs to
23.29 administer the grant under this section. The commissioner must publish on the department's
23.30 website an annual report on the fines assessed and collected, and how the appropriated
23.31 money was allocated.

24.1 Sec. 7. Minnesota Statutes 2025 Supplement, section 144A.4799, subdivision 1, is amended
24.2 to read:

24.3 Subdivision 1. **Membership.** (a) The commissioner of health shall appoint 14 persons
24.4 to a home care and assisted living advisory council consisting of the following:

24.5 (1) four public members as defined in section 214.02, one of whom must be a person
24.6 who either is receiving or has received home care services preferably within the five years
24.7 prior to initial appointment, one of whom must be a person who has or had a family member
24.8 receiving home care services preferably within the five years prior to initial appointment,
24.9 one of whom must be a person who either is or has been a resident in an assisted living
24.10 facility preferably within the five years prior to initial appointment, and one of whom must
24.11 be a person who has or had a family member residing in an assisted living facility preferably
24.12 within the five years prior to initial appointment;

24.13 (2) two Minnesota home care licensees representing basic and comprehensive levels of
24.14 licensure who may be a managerial official, an administrator, a supervising registered nurse,
24.15 or an unlicensed personnel performing home care tasks;

24.16 (3) one member representing the Minnesota Board of Nursing;

24.17 (4) one member representing the Office of Ombudsman for Long-Term Care;

24.18 (5) one member representing the Office of Ombudsman for Mental Health and
24.19 Developmental Disabilities;

24.20 (6) one member of a county health and human services or county adult protection office;

24.21 (7) two Minnesota assisted living facility licensees representing assisted living facilities
24.22 and assisted living facilities with dementia care levels of licensure who may be the facility's
24.23 assisted living director, managerial official, or clinical nurse supervisor;

24.24 (8) one organization representing long-term care providers, home care providers, and
24.25 assisted living providers in Minnesota; and

24.26 (9) one representative of a consumer advocacy organization representing individuals
24.27 receiving long-term care from licensed home care providers or assisted living facilities.

24.28 (b) When a vacancy occurs for an appointment identified in paragraph (a), the
24.29 commissioner must select an applicant for appointment within 81 calendars days of the
24.30 position being posted by the secretary of state if the application of a qualified and, if
24.31 applicable, a licensee in good standing applicant is received within 21 days of posting. If
24.32 no qualified applications are received within the first 21 days, the commissioner must select

25.1 an applicant for appointment within 60 calendar days of receiving the application of a
25.2 qualified and, if applicable, a licensee in good standing applicant.

25.3 Sec. 8. Minnesota Statutes 2024, section 144A.72, subdivision 2, is amended to read:

25.4 Subd. 2. **Penalties.** (a) Failure to comply with this section shall subject the supplemental
25.5 nursing services agency to revocation or nonrenewal of its registration. Violations of section
25.6 144A.74 are subject to a fine equal to 200 percent of the amount billed or received in excess
25.7 of the maximum permitted under that section.

25.8 (b) The commissioner may request and must be given access to relevant information,
25.9 records, incident reports, or other documents in the possession of a facility if the
25.10 commissioner considers them necessary to verify a supplemental nursing services agency's
25.11 compliance with this section. The commissioner may bring enforcement action against a
25.12 supplemental nursing services agency or facility that fails to provide the commissioner with
25.13 information, records, reports, or other documents requested under this paragraph.

25.14 Sec. 9. Minnesota Statutes 2024, section 144G.08, is amended by adding a subdivision to
25.15 read:

25.16 Subd. 26a. **Imminent risk.** "Imminent risk" means an immediate and impending threat
25.17 to the health, safety, or rights of an individual.

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

25.19 Sec. 10. Minnesota Statutes 2024, section 144G.08, is amended by adding a subdivision
25.20 to read:

25.21 Subd. 54a. **Prone restraint.** "Prone restraint" means the use of manual restraint that
25.22 places a resident in a face-down position. Prone restraint does not include the brief physical
25.23 holding of a resident who, during an emergency use of a manual restraint, rolls into a prone
25.24 position and as quickly as possible the resident is restored to a standing, sitting, or side-lying
25.25 position.

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

25.27 Sec. 11. Minnesota Statutes 2024, section 144G.08, is amended by adding a subdivision
25.28 to read:

25.29 Subd. 61a. **Restraint.** "Restraint" means:

25.30 (1) chemical restraint, as defined in section 245D.02, subdivision 3b;

- 26.1 (2) manual restraint, as defined in section 245D.02, subdivision 15a;
26.2 (3) mechanical restraint, as defined in section 245D.02, subdivision 15b; or
26.3 (4) any other form of restraint that limits the free and normal movement of body or
26.4 limbs.

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

26.6 Sec. 12. Minnesota Statutes 2024, section 144G.19, is amended by adding a subdivision
26.7 to read:

26.8 **Subd. 6. Correction orders and fines.** After a change of ownership, the new licensee
26.9 is responsible for any outstanding fines and any fines assessed following the effective date
26.10 of the change of ownership regardless of the date of the violation. Additionally, the new
26.11 licensee is responsible for bringing the facility into compliance with all existing ordered,
26.12 imposed or agreed-upon corrections and conditions.

26.13 Sec. 13. Minnesota Statutes 2024, section 144G.31, subdivision 6, is amended to read:

26.14 **Subd. 6. Payment of fines required.** When a fine has been assessed, the licensee may
26.15 not avoid payment by closing, selling, or otherwise transferring the license to a third party
26.16 the license. In such an event, the licensee shall be liable for payment of the fine. In the event
26.17 of a change of ownership, the new licensee is responsible for any outstanding fines and any
26.18 fines assessed following the effective date of the change of ownership regardless of the date
26.19 of the violation.

26.20 Sec. 14. **[144G.65] TRAINING IN EMERGENCY MANUAL RESTRAINTS.**

26.21 **Subdivision 1. Training.** A licensee must ensure that staff who are authorized to apply
26.22 an emergency use of a manual restraint complete a minimum of four hours of training from
26.23 a qualified individual prior to assuming these responsibilities. Training must include:

- 26.24 (1) types of behaviors, de-escalation techniques and their value;
26.25 (2) principles of person-centered planning and service delivery as identified in section
26.26 245D.07, subdivision 1a, paragraph (b);
26.27 (3) what constitutes the use of a restraint;
26.28 (4) staff responsibilities related to: (i) prohibited procedures under section 144G.85; (ii)
26.29 why prohibited procedures are not effective for reducing or eliminating symptoms or
26.30 interfering behavior; and (iii) why prohibited procedures are not safe;

27.1 (5) the situations when staff must contact 911 services in response to an imminent risk
27.2 of harm to the resident or others; and

27.3 (6) strategies for respecting and supporting each resident's cultural preferences.

27.4 Subd. 2. **Annual refresher training.** The licensee must ensure that staff who apply an
27.5 emergency use of a manual restraint complete two hours of refresher training on an annual
27.6 basis covering each of the training areas listed in subdivision 1.

27.7 Subd. 3. **Implementation.** The assisted living facility must implement all orientation
27.8 and training topics covered in this section.

27.9 Subd. 4. **Verification and documentation of orientation and training.** For staff who
27.10 are authorized to apply an emergency use of a manual restraint, the assisted living facility
27.11 must retain evidence in the employee record of each staff person having completed the
27.12 orientation and training under this section.

27.13 Subd. 5. **Exemption.** This section does not apply to licensees who have a policy
27.14 prohibiting the use of restraints.

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

27.16 Sec. 15. **[144G.85] USE OF RESTRAINTS.**

27.17 Subdivision 1. **Use of restraints prohibited.** Restraints are prohibited except as described
27.18 in subdivisions 2 and 4.

27.19 Subd. 2. **Exception.** (a) Emergency use of a manual restraint is permitted only when
27.20 immediate intervention is needed to protect the resident or others from imminent risk of
27.21 physical harm and is the least restrictive intervention to address the risk. The restraint must
27.22 be imposed for the least amount of time necessary and removed when there is no longer
27.23 imminent risk of physical harm to the resident or other persons in the facility. The use of
27.24 restraint under this subdivision must:

27.25 (1) take into consideration the rights, health, and welfare of the resident;

27.26 (2) not apply pressure to the back or chest while a resident is in a prone, supine, or
27.27 side-lying position; and

27.28 (3) allow the resident to be free from prone restraint.

27.29 (b) This section does not apply when a resident, a resident's legal representative, or a
27.30 family member acting on the resident's behalf chooses to utilize a bed rail or other device
27.31 that may constitute a restraint, after being informed of the facility's policy prohibiting the

28.1 use of restraints and of the risks of using the device. The facility must document that the
28.2 resident, resident's legal representative, or family member received information regarding
28.3 the facility's policy and the risks of using the device and voluntarily elected to use the device.

28.4 Subd. 3. **Documentation and notification.** (a) The resident's legal representative must
28.5 be notified within 24 hours of an emergency use of a manual restraint and of the
28.6 circumstances that prompted the use. Notification and the emergency use of a manual
28.7 restraint must be documented. If known, the advanced practice registered nurse, physician,
28.8 or physician assistant must be notified within 24 hours of an emergency use of a manual
28.9 restraint.

28.10 (b) On a form developed by the commissioner, the facility must notify the commissioner
28.11 and the ombudsman for long-term care within seven calendar days of any emergency use
28.12 of a manual restraint, including when any restraint is first applied or ordered. The
28.13 commissioner will monitor reported uses to detect overuse or unauthorized, inappropriate,
28.14 or ineffective use of the restraint. The form must include:

28.15 (1) the name and date of birth of the resident;

28.16 (2) the date and time of the use of the restraint;

28.17 (3) the names of staff and any residents who were involved in the incident leading up
28.18 to the emergency use of a manual restraint;

28.19 (4) a description of the incident, including the length of time the restraint was applied
28.20 and who was present before and during the incident leading up to the emergency use of a
28.21 manual restraint;

28.22 (5) a description of what less restrictive alternative measures were attempted to de-escalate
28.23 the incident and maintain safety that identifies when, how, and for how long the alternative
28.24 measures were attempted before the emergency use of a manual restraint was implemented;

28.25 (6) a description of the mental, physical, and emotional condition of the resident who
28.26 was restrained and of other persons involved in the incident leading up to, during, and
28.27 following the emergency use of a manual restraint;

28.28 (7) whether there was any injury to the resident who was restrained or other persons
28.29 involved in the incident, including staff, before or as a result of the emergency use of a
28.30 manual restraint; and

28.31 (8) whether there was a debriefing following the incident with the staff, and, if not
28.32 contraindicated, with the resident who was restrained and other persons who were involved
28.33 in or who witnessed the emergency use of a manual restraint, and the outcome of the

29.1 debriefing. If the debriefing was not conducted at the time the incident report was made,
 29.2 the form should identify whether a debriefing is planned and a plan for mitigating use of
 29.3 restraints in the future.

29.4 (c) A copy of the form submitted under paragraph (b) must be maintained in the resident's
 29.5 record.

29.6 (d) A copy of the form submitted under paragraph (b) must be sent to the resident's
 29.7 waiver case manager within seven calendar days of the emergency use of manual restraints.
 29.8 An emergency use of manual restraints on people served under section 256B.49 and chapter
 29.9 256S must be documented by the case manager in the resident's support plan, as defined in
 29.10 sections 256B.49, subdivision 15, and 256S.10.

29.11 (e) The use of restraints by law enforcement officers or other emergency personnel acting
 29.12 in a licensed capacity does not require the facility to comply with the requirements of this
 29.13 subdivision.

29.14 Subd. 4. **Ordered treatment.** The use of a restraint, other than an emergency use of a
 29.15 manual restraint to address an imminent risk, that is part of an ordered treatment must
 29.16 comply with the requirements for ordered treatment under section 144G.72 and must be the
 29.17 least restrictive option.

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

29.19 Sec. 16. Minnesota Statutes 2024, section 157.17, subdivision 2, is amended to read:

29.20 Subd. 2. **Registration.** At the time of licensure or license renewal, a boarding and lodging
 29.21 establishment or a lodging establishment that provides supportive services or health
 29.22 supervision services must be registered with the commissioner, and must register annually
 29.23 thereafter. The registration must include the name, address, and telephone number of the
 29.24 establishment, the name of the operator, the types of services that are being provided, a
 29.25 description of the residents being served, the type and qualifications of staff in the facility,
 29.26 and other information that is necessary to identify the needs of the residents and the types
 29.27 of services that are being provided. The commissioner shall develop and furnish to the
 29.28 boarding and lodging establishment or lodging establishment the necessary form for
 29.29 submitting the registration.

29.30 ~~Housing with services establishments registered under chapter 144D shall be considered~~
 29.31 ~~registered under this section for all purposes except that:~~

29.32 ~~(1) the establishments shall operate under the requirements of chapter 144D; and~~

30.1 ~~(2) the criminal background check requirements of sections 299C.66 to 299C.71 apply.~~
30.2 ~~The criminal background check requirements of section 144.057 apply only to personnel~~
30.3 ~~providing home care services under sections 144A.43 to 144A.47 and personnel providing~~
30.4 ~~hospice care under sections 144A.75 to 144A.755.~~

30.5 Sec. 17. Minnesota Statutes 2024, section 157.17, subdivision 5, is amended to read:

30.6 Subd. 5. **Services that may not be provided in a boarding and lodging establishment**
30.7 **or lodging establishment.** ~~Except those facilities registered under chapter 144D,~~ A boarding
30.8 and lodging establishment or lodging establishment may not admit or retain individuals
30.9 who:

30.10 (1) would require assistance from establishment staff because of the following needs:
30.11 bowel incontinence, catheter care, use of injectable or parenteral medications, wound care,
30.12 or dressing changes or irrigations of any kind; or

30.13 (2) require a level of care and supervision beyond supportive services or health
30.14 supervision services.

30.15 Sec. 18. Minnesota Statutes 2024, section 295.50, subdivision 4, is amended to read:

30.16 Subd. 4. **Health care provider.** (a) "Health care provider" means:

30.17 (1) a person whose health care occupation is regulated or required to be regulated by
30.18 the state of Minnesota furnishing any or all of the following goods or services directly to a
30.19 patient or consumer: medical, surgical, optical, visual, dental, hearing, nursing services,
30.20 drugs, laboratory, diagnostic or therapeutic services;

30.21 (2) a person who provides goods and services not listed in clause (1) that qualify for
30.22 reimbursement under the medical assistance program provided under chapter 256B;

30.23 (3) a staff model health plan company;

30.24 (4) an ambulance service required to be licensed;

30.25 (5) a person who sells or repairs hearing aids and related equipment or prescription
30.26 eyewear; or

30.27 (6) a person providing patient services, who does not otherwise meet the definition of
30.28 health care provider and is not specifically excluded in clause (b), who employs or contracts
30.29 with a health care provider as defined in clauses (1) to (5) to perform, supervise, otherwise
30.30 oversee, or consult with regarding patient services.

30.31 (b) Health care provider does not include:

31.1 (1) hospitals; medical supplies distributors, except as specified under paragraph (a),
31.2 clause (5); nursing homes licensed under chapter 144A or licensed in any other jurisdiction;
31.3 wholesale drug distributors; pharmacies; surgical centers; bus and taxicab transportation,
31.4 or any other providers of transportation services other than ambulance services required to
31.5 be licensed; supervised living facilities for persons with developmental disabilities, licensed
31.6 under Minnesota Rules, parts 4665.0100 to 4665.9900; ~~housing with services establishments~~
31.7 ~~required to be registered under chapter 144D~~; board and lodging establishments providing
31.8 only custodial services that are licensed under chapter 157 and registered under section
31.9 157.17 to provide supportive services or health supervision services; adult foster homes as
31.10 defined in Minnesota Rules, part 9555.5105; day training and habilitation services for adults
31.11 with developmental disabilities as defined in section 252.41, subdivision 3; boarding care
31.12 homes, as defined in Minnesota Rules, part 4655.0100; and adult day care centers as defined
31.13 in Minnesota Rules, part 9555.9600;

31.14 (2) home health agencies as defined in Minnesota Rules, part 9505.0175, subpart 15; a
31.15 person providing personal care assistance services and supervision of personal care assistance
31.16 services as defined in ~~Minnesota Rules, part 9505.0335~~ section 256B.0625, subdivision
31.17 19a; a person providing home care nursing services as defined in Minnesota Rules, part
31.18 9505.0360; and home care providers required to be licensed under chapter 144A for home
31.19 care services provided under chapter 144A;

31.20 (3) a person who employs health care providers solely for the purpose of providing
31.21 patient services to its employees;

31.22 (4) an educational institution that employs health care providers solely for the purpose
31.23 of providing patient services to its students if the institution does not receive fee for service
31.24 payments or payments for extended coverage; and

31.25 (5) a person who receives all payments for patient services from health care providers,
31.26 surgical centers, or hospitals for goods and services that are taxable to the paying health
31.27 care providers, surgical centers, or hospitals, as provided under section 295.53, subdivision
31.28 1, paragraph (b), clause (3) or (4), or from a source of funds that is excluded or exempt from
31.29 tax under sections 295.50 to 295.59.

31.30 Sec. 19. Minnesota Statutes 2025 Supplement, section 295.50, subdivision 9b, is amended
31.31 to read:

31.32 Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services
31.33 and other goods and services provided by hospitals, surgical centers, or health care providers.
31.34 They include the following health care goods and services provided to a patient or consumer:

- 32.1 (1) bed and board;
- 32.2 (2) nursing services and other related services;
- 32.3 (3) use of hospitals, surgical centers, or health care provider facilities;
- 32.4 (4) medical social services;
- 32.5 (5) drugs, biologicals, supplies, appliances, and equipment;
- 32.6 (6) other diagnostic or therapeutic items or services;
- 32.7 (7) medical or surgical services;
- 32.8 (8) items and services furnished to ambulatory patients not requiring emergency care;
- 32.9 and
- 32.10 (9) emergency services.
- 32.11 (b) "Patient services" does not include:
- 32.12 (1) services provided to nursing homes licensed under chapter 144A;
- 32.13 (2) examinations for purposes of utilization reviews, insurance claims or eligibility,
- 32.14 litigation, and employment, including reviews of medical records for those purposes;
- 32.15 (3) services provided to and by community residential mental health facilities licensed
- 32.16 under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by
- 32.17 residential treatment programs for children with a serious mental illness licensed or certified
- 32.18 under chapter 245A;
- 32.19 (4) services provided under the following programs: day treatment services as defined
- 32.20 in section 245.462, subdivision 8; assertive community treatment as described in section
- 32.21 256B.0622; adult rehabilitative mental health services as described in section 256B.0623;
- 32.22 crisis response services as described in section 256B.0624; and children's therapeutic services
- 32.23 and supports as described in section 256B.0943;
- 32.24 (5) services provided to and by community mental health centers as defined in section
- 32.25 245.62, subdivision 2;
- 32.26 (6) services provided to and by assisted living programs and congregate housing
- 32.27 programs;
- 32.28 (7) hospice care services;
- 32.29 (8) home and community-based waived services under chapter 256S and sections
- 32.30 256B.49 and 256B.501;

33.1 (9) targeted case management services under sections 256B.0621; 256B.0625,
 33.2 subdivisions 20, 20a, 33, and 44; and 256B.094; and

33.3 (10) services provided to the following: supervised living facilities for persons with
 33.4 developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;
 33.5 ~~housing with services establishments required to be registered under chapter 144D~~; board
 33.6 and lodging establishments providing only custodial services that are licensed under chapter
 33.7 157 and registered under section 157.17 to provide supportive services or health supervision
 33.8 services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training
 33.9 and habilitation services for adults with developmental disabilities as defined in section
 33.10 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100;
 33.11 adult day care services as defined in section 245A.02, subdivision 2a; and home health
 33.12 agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under
 33.13 chapter 144A.

33.14 Sec. 20. **SPECIAL PROJECTS GRANT PROGRAM FOR HOME CARE**
 33.15 **PROVIDERS.**

33.16 By December 31, 2028, the commissioner of health must distribute the balance as of
 33.17 January 1, 2027, in the special revenue account under Minnesota Statutes, section 144A.474,
 33.18 subdivision 11, paragraph (j), under a competitive grant program for special projects for
 33.19 improving home care client quality of care and outcomes in Minnesota, with a specific focus
 33.20 on workforce and clinical outcomes, including projects consistent with criteria in Minnesota
 33.21 Statutes, section 144A.4799, subdivision 3, paragraph (c). Grants must be distributed to
 33.22 home care providers licensed under Minnesota Statutes, chapter 144A, or organizations
 33.23 with experience in or knowledge of home care operations, compliance, client needs, or best
 33.24 practices. Each grant must be at least \$1,000. A provider with a temporary license under
 33.25 Minnesota Statutes, chapter 144A, is not eligible to apply for a grant. Any amount that has
 33.26 not been awarded as a grant by December 31, 2028, must be used for the annual distributions
 33.27 under Minnesota Statutes, section 144A.474, subdivision 11, paragraph (j), beginning
 33.28 January 1, 2029.

ARTICLE 3

HEALTH CARE POLICY

34.1
34.2
34.3 Section 1. Minnesota Statutes 2025 Supplement, section 15.013, is amended by adding a
34.4 subdivision to read:

34.5 Subd. 7. **Exemption.** Nothing in this section modifies, supersedes, limits, or expands
34.6 the authority of the commissioner of human services to impose sanctions under section
34.7 256B.064.

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

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

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

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

34.14 Sec. 3. **[256B.0435] PREPAYMENT REVIEW.**

34.15 Subdivision 1. **Providers subject to prepayment review.** (a) The commissioner must
34.16 establish prepayment review of submitted medical assistance claims when the commissioner
34.17 or the Centers for Medicare and Medicaid Services designates:

34.18 (1) a provider type as high-risk under section 256B.04, subdivision 21, paragraph (j),
34.19 for fee-for-service claims submitted by providers within that category; and

34.20 (2) a covered service as high-risk, for fee-for-service claims submitted for that service
34.21 by any provider, except the Indian Health Service.

34.22 (b) Nothing in this section prevents the commissioner from establishing prepayment
34.23 review in other circumstances if required by the Centers for Medicare and Medicaid Services.

34.24 Subd. 2. **Review requirements.** (a) The commissioner must implement a prepayment
34.25 review established under subdivision 1, paragraph (a), within 15 days of the date of the
34.26 high-risk designation, effective for a period of up to 24 months from the date the review is
34.27 implemented.

34.28 (b) A prepayment review established under subdivision 1, paragraph (a), must comply
34.29 with the timely processing of claims requirements under Code of Federal Regulations, title
34.30 42, section 447.45.

35.1 (c) Before ending prepayment review under subdivision 1, paragraph (a), clause (1), the
35.2 commissioner must review all fee-for-service claims submitted by providers subject to the
35.3 prepayment review in the 24 months preceding the date the provider type was designated
35.4 high-risk.

35.5 Subd. 3. **Continued enrollment of new clients.** Nothing in this section prohibits an
35.6 enrolled provider that is subject to prepayment review under subdivision 1, paragraph (a),
35.7 from enrolling new clients or beneficiaries during the period of the review.

35.8 Subd. 4. **Notice.** At least ten days prior to implementing a prepayment review, the
35.9 commissioner must notify enrolled providers subject to the review and the chairs and ranking
35.10 minority members of the legislative committees with jurisdiction over health and human
35.11 services policy and finance about the prepayment review the commissioner plans to
35.12 implement under this section. The notice must:

35.13 (1) include a list of provider types or covered services to which prepayment review
35.14 applies;

35.15 (2) provide a general explanation for the basis of the review; and

35.16 (3) identify the start date and anticipated duration of the prepayment review.

35.17 Subd. 5. **Report to the legislature.** (a) Within 60 days of ending a prepayment review,
35.18 the commissioner must submit a report to the chairs and ranking minority members of the
35.19 legislative committees with jurisdiction over health and human services policy and finance.
35.20 The report must include, at a minimum:

35.21 (1) a summary of any sanctions imposed under section 256B.064 on any providers subject
35.22 to prepayment review; and

35.23 (2) recommendations for modifying or terminating the provision of covered services
35.24 deemed high-risk or delivered by provider types subject to prepayment review.

35.25 (b) Notwithstanding section 256.01, subdivision 42, this subdivision does not expire.

35.26 Sec. 4. Minnesota Statutes 2024, section 256B.064, subdivision 1b, is amended to read:

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

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

36.1 (2) withholding payments to an individual or entity;

36.2 (3) suspending participation in the program;

36.3 (4) terminating participation in the program; or

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

36.5 (b) When imposing sanctions under this ~~section~~ subdivision, the commissioner ~~shall~~
 36.6 must consider the nature, chronicity, or severity of the conduct and the effect of the conduct

36.7 on the health and safety of persons served by the individual or entity.

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

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

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

36.16 Sec. 5. Minnesota Statutes 2024, section 256B.064, subdivision 1c, is amended to read:

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

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

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

37.1 Sec. 6. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

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

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

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

37.10 Sec. 7. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

37.11 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The
37.12 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions
37.13 to be imposed upon an individual or entity under this section. Except as provided in
37.14 ~~paragraphs (b) and (d), neither~~ subdivisions 2b to 2d, the commissioner must not obtain a
37.15 monetary recovery ~~nor~~ or impose a sanction ~~will be imposed by the commissioner~~ without
37.16 prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's
37.17 proposed action, ~~provided that the commissioner may suspend or reduce payment to an~~
37.18 individual or entity, ~~except a nursing home or convalescent care facility, after notice and~~
37.19 prior to the hearing if in the commissioner's opinion that action is necessary to protect the
37.20 public welfare and the interests of the program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39.3 ~~(f)~~ (b) Upon receipt of a notice under paragraph (a) or subdivision 2c or 2d that a
39.4 monetary recovery or sanction is to be imposed, an individual or entity may request a
39.5 contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner
39.6 a written request of appeal. The appeal request must be received by the commissioner no
39.7 later than 30 days after the date the notification of monetary recovery or sanction was mailed
39.8 to the individual or entity. The appeal request must specify:

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

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

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

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

39.16 (5) other information required by the commissioner.

39.17 ~~(g) The commissioner may order an individual or entity to forfeit a fine for failure to~~
39.18 ~~fully document services according to standards in this chapter and Minnesota Rules, chapter~~
39.19 ~~9505. The commissioner may assess fines if specific required components of documentation~~
39.20 ~~are missing. The fine for incomplete documentation shall equal 20 percent of the amount~~
39.21 ~~paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000,~~
39.22 ~~whichever is less. If the commissioner determines that an individual or entity repeatedly~~
39.23 ~~violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to~~
39.24 ~~the provision of services to program recipients and the submission of claims for payment,~~
39.25 ~~the commissioner may order an individual or entity to forfeit a fine based on the nature,~~
39.26 ~~severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the~~
39.27 ~~value of the claims, whichever is greater.~~

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

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

40.1 Sec. 8. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
40.2 to read:

40.3 Subd. 2a. **Imposition of fines.** (a) The commissioner may order an individual or entity
40.4 to forfeit a fine for failure to fully document services according to standards in this chapter
40.5 and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required
40.6 components of documentation are missing. The fine for incomplete documentation equals
40.7 20 percent of the amount paid on the claims for reimbursement submitted by the individual
40.8 or entity or up to \$5,000, whichever is less. If the commissioner determines that an individual
40.9 or entity repeatedly violated this chapter, chapter 245G or 254B, or Minnesota Rules, chapter
40.10 9505, related to the provision of services to program recipients and the submission of claims
40.11 for payment, the commissioner may order an individual or entity to forfeit a fine based on
40.12 the nature, severity, and chronicity of the violations in an amount of up to \$5,000 or 20
40.13 percent of the value of the claims, whichever is greater.

40.14 (b) The individual or entity must pay the fine assessed on or before the payment date
40.15 specified by the commissioner. If the individual or entity fails to pay the fine, the
40.16 commissioner may withhold or reduce payments and recover the amount of the fine. A
40.17 timely appeal stays payment of the fine until the commissioner issues a final order.

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

40.19 Sec. 9. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
40.20 to read:

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

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

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

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

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

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

41.2 Sec. 10. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
41.3 to read:

41.4 **Subd. 2c. Imposition of withholding or reduction of payments before a hearing.** (a)
41.5 Except as provided in paragraph (b), the commissioner may withhold or reduce payment
41.6 to an individual or entity after notice but before a hearing if, in the commissioner's opinion,
41.7 withholding or reducing payment is necessary to protect the public welfare and the interests
41.8 of the program.

41.9 (b) The commissioner must not withhold or reduce payments to a nursing home or
41.10 convalescent care facility before a hearing.

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

41.12 Sec. 11. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
41.13 to read:

41.14 **Subd. 2d. Imposition of withholding or reduction of payments without prior**
41.15 **notice.** (a) Except when the commissioner finds good cause not to suspend payments under
41.16 Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner must
41.17 withhold or reduce payments to an individual or entity without providing advance notice
41.18 of the withholding or reduction if either of the following occurs:

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

41.21 (2) the commissioner determines there is a credible allegation of fraud for which an
41.22 investigation is pending under the program. Allegations are considered credible when the
41.23 allegations have an indicium of reliability and the state agency has reviewed all allegations,
41.24 facts, and evidence carefully and acts judiciously on a case-by-case basis. A credible
41.25 allegation of fraud is an allegation that has been verified by the state from any source,
41.26 including but not limited to:

41.27 (i) fraud hotline complaints;

41.28 (ii) claims data mining; and

41.29 (iii) patterns identified through provider audits, civil false claims cases, and law
41.30 enforcement investigations.

42.1 (b) The commissioner must send notice of the withholding or reduction of payments
 42.2 under paragraph (a) within five days of withholding or reducing payment unless requested
 42.3 in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

42.4 (1) state that payments are being withheld according to paragraph (a);

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

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

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

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

42.13 (c) The commissioner must cease the withholding or reduction of payments under this
 42.14 subdivision after the commissioner determines there is insufficient evidence of fraud by the
 42.15 individual or entity or after legal proceedings relating to the alleged fraud are completed,
 42.16 unless the commissioner has sent notice of intent to impose monetary recovery or sanctions.

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

42.18 Sec. 12. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
 42.19 to read:

42.20 Subd. 2e. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction
 42.21 for a crime related to the provision, management, or administration of a health service under
 42.22 medical assistance, a payment held pursuant to this section by the commissioner or a managed
 42.23 care organization that contracts with the commissioner under section 256B.035 is forfeited
 42.24 to the commissioner or managed care organization, regardless of the amount charged in the
 42.25 criminal complaint or the amount of criminal restitution ordered.

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

42.27 Sec. 13. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

42.28 Subd. 3. **Mandates on prohibited payments.** (a) The commissioner ~~shall~~ must maintain
 42.29 and publish a list of each excluded individual and entity that was convicted of a crime related
 42.30 to the provision, management, or administration of a medical assistance health service, or
 42.31 suspended or terminated under subdivision ~~2~~ 2b. Medical assistance payments cannot be

43.1 made by an individual or entity for items or services furnished either directly or indirectly
43.2 by an excluded individual or entity, or at the direction of excluded individuals or entities.

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

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

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

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

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

43.20 (3) other fines or penalties allowed by law.

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

43.22 Sec. 14. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

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

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

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

44.1 Sec. 15. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

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

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

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

44.12 (d) After an investigation is complete, the reporter's name must be kept confidential.
44.13 The subject of the report may compel disclosure of the reporter's name only with the consent
44.14 of the reporter or upon a written finding by a district court that the report was false and there
44.15 is evidence that the report was made in bad faith. This subdivision does not alter disclosure
44.16 responsibilities or obligations under the Rules of Criminal Procedure, except that when the
44.17 identity of the reporter is relevant to a criminal prosecution the district court ~~shall~~ must
44.18 conduct an in-camera review before determining whether to order disclosure of the reporter's
44.19 identity.

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

44.21 Sec. 16. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
44.22 to read:

44.23 Subd. 6. **Application.** This section supersedes any inconsistent or contrary provision of
44.24 law.

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

44.26 ARTICLE 4

44.27 MEDICAL ASSISTANCE PROVIDER ENROLLMENT

44.28 Section 1. Minnesota Statutes 2024, section 142B.01, subdivision 8, is amended to read:

44.29 Subd. 8. **Controlling individual.** (a) "Controlling individual" means an owner of a
44.30 program or service provider licensed under this chapter and the following individuals, if
44.31 applicable:

45.1 (1) each officer of the organization, including the chief executive officer and chief
45.2 financial officer;

45.3 (2) the individual designated as the authorized agent under section 142B.10, subdivision
45.4 1, paragraph (b);

45.5 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
45.6 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

45.7 (4) each managerial official whose responsibilities include the direction of the
45.8 management or policies of a program;

45.9 (5) the individual designated as the primary provider of care for a special family child
45.10 care program under section 142B.41, subdivision 4, paragraph (d); and

45.11 (6) the president and treasurer of the board of directors of a nonprofit corporation.

45.12 (b) Controlling individual does not include:

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

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

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

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

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

45.25 (4) an individual who is a member of an organization exempt from taxation under section
45.26 290.05, unless the individual is also an officer, owner, or managerial official of the program
45.27 or owns any of the beneficial interests not excluded in this subdivision. This clause does
45.28 not exclude from the definition of controlling individual an organization that is exempt from
45.29 taxation; or

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

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

46.6 Sec. 2. Minnesota Statutes 2024, section 245A.02, subdivision 5a, is amended to read:

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

46.10 (1) each officer of the organization, including the chief executive officer and chief
46.11 financial officer;

46.12 (2) the individual designated as the authorized agent under section 245A.04, subdivision
46.13 1, paragraph (b);

46.14 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
46.15 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

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

46.19 (b) Controlling individual does not include:

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

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

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

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

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

47.1 (4) an individual who is a member of an organization exempt from taxation under section
47.2 290.05, unless the individual is also an officer, owner, or managerial official of the program
47.3 or owns any of the beneficial interests not excluded in this subdivision. This clause does
47.4 not exclude from the definition of controlling individual an organization that is exempt from
47.5 taxation; or

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

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

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

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

47.19 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
47.20 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
47.21 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~
47.22 256B.044, subdivision 8;

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

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

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

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

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

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

48.8 (b) The designated manager must be competent to perform the duties as required and
48.9 must minimally meet the education and training requirements identified in subdivision 2,
48.10 paragraph (b), and have a minimum of three years of supervisory level experience in a
48.11 program that provides care or education to vulnerable adults or children.

48.12 Sec. 4. Minnesota Statutes 2024, section 256B.04, subdivision 5, is amended to read:

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

48.20 Sec. 5. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
48.21 to read:

48.22 Subd. 21. **Provider enrollment.** ~~(a)~~ The commissioner shall enroll providers and conduct
48.23 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
48.24 E, and sections 256B.044 to 256B.0445.

48.25 ~~A provider must enroll each provider-controlled location where direct services are~~
48.26 ~~provided. The commissioner may deny a provider's incomplete application if a provider~~
48.27 ~~fails to respond to the commissioner's request for additional information within 60 days of~~
48.28 ~~the request. The commissioner must conduct a background study under chapter 245C,~~
48.29 ~~including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses~~
48.30 ~~(1) to (5), for a provider described in this paragraph. The background study requirement~~
48.31 ~~may be satisfied if the commissioner conducted a fingerprint-based background study on~~

49.1 ~~the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph~~
49.2 ~~(a), clauses (1) to (5).~~

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

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

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

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

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

49.10 ~~(c) The commissioner shall conduct revalidation as follows:~~

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

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

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

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

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

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

49.30 ~~(g) An enrolled provider that is also licensed by the commissioner under chapter 245A,~~
49.31 ~~is licensed as a home care provider by the Department of Health under chapter 144A, or is~~
49.32 ~~licensed as an assisted living facility under chapter 144G and has a home and~~

50.1 ~~community-based services designation on the home care license under section 144A.484,~~
50.2 ~~must designate an individual as the entity's compliance officer. The compliance officer~~
50.3 ~~must:~~

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

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

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

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

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

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

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

50.20 ~~(h) The commissioner may revoke the enrollment of an ordering or rendering provider~~
50.21 ~~for a period of not more than one year, if the provider fails to maintain and, upon request~~
50.22 ~~from the commissioner, provide access to documentation relating to written orders or requests~~
50.23 ~~for payment for durable medical equipment, certifications for home health services, or~~
50.24 ~~referrals for other items or services written or ordered by such provider, when the~~
50.25 ~~commissioner has identified a pattern of a lack of documentation. A pattern means a failure~~
50.26 ~~to maintain documentation or provide access to documentation on more than one occasion.~~
50.27 ~~Nothing in this paragraph limits the authority of the commissioner to sanction a provider~~
50.28 ~~under the provisions of section 256B.064.~~

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

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

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

51.5 ~~(3) serves primarily a pediatric population.~~

51.6 ~~(j) As a condition of enrollment in medical assistance, the commissioner shall require~~
51.7 ~~that a provider designated "moderate" or "high-risk" by the Centers for Medicare and~~
51.8 ~~Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid~~
51.9 ~~Services, its agents, or its designated contractors and the state agency, its agents, or its~~
51.10 ~~designated contractors to conduct unannounced on-site inspections of any provider location.~~
51.11 ~~The commissioner shall publish in the Minnesota Health Care Program Provider Manual a~~
51.12 ~~list of provider types designated "limited," "moderate," or "high-risk," based on the criteria~~
51.13 ~~and standards used to designate Medicare providers in Code of Federal Regulations, title~~
51.14 ~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.~~
51.15 ~~The commissioner's designations are not subject to administrative appeal.~~

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

51.22 ~~(l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable~~
51.23 ~~medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers~~
51.24 ~~meeting the durable medical equipment provider and supplier definition in clause (3),~~
51.25 ~~operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is~~
51.26 ~~annually renewed and designates the Minnesota Department of Human Services as the~~
51.27 ~~obligee, and must be submitted in a form approved by the commissioner. For purposes of~~
51.28 ~~this clause, the following medical suppliers are not required to obtain a surety bond: a~~
51.29 ~~federally qualified health center, a home health agency, the Indian Health Service, a~~
51.30 ~~pharmacy, and a rural health clinic.~~

51.31 ~~(2) At the time of initial enrollment or reenrollment, durable medical equipment providers~~
51.32 ~~and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating~~
51.33 ~~provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,~~
51.34 ~~the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's~~

52.1 ~~Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must~~
52.2 ~~purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and~~
52.3 ~~fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions~~
52.4 ~~from a surety bond must occur within six years from the date the debt is affirmed by a final~~
52.5 ~~agency decision. An agency decision is final when the right to appeal the debt has been~~
52.6 ~~exhausted or the time to appeal has expired under section 256B.064.~~

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

52.11 ~~(m) The Department of Human Services may require a provider to purchase a surety~~
52.12 ~~bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment~~
52.13 ~~if: (1) the provider fails to demonstrate financial viability, (2) the department determines~~
52.14 ~~there is significant evidence of or potential for fraud and abuse by the provider, or (3) the~~
52.15 ~~provider or category of providers is designated high-risk pursuant to paragraph (f) and as~~
52.16 ~~per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an~~
52.17 ~~amount of \$100,000 or ten percent of the provider's payments from Medicaid during the~~
52.18 ~~immediately preceding 12 months, whichever is greater. The surety bond must name the~~
52.19 ~~Department of Human Services as an obligee and must allow for recovery of costs and fees~~
52.20 ~~in pursuing a claim on the bond. This paragraph does not apply if the provider currently~~
52.21 ~~maintains a surety bond under the requirements in section 256B.051, 256B.0659, 256B.0701,~~
52.22 ~~or 256B.85.~~

52.23 **Sec. 6. [256B.044] PROVIDER ENROLLMENT.**

52.24 Subdivision 1. Designating categorical risk levels. (a) The commissioner must designate
52.25 provider types as "limited-risk," "moderate-risk," or "high-risk" based on the criteria and
52.26 standards used to designate Medicare providers in Code of Federal Regulations, title 42,
52.27 section 424.518. The commissioner must publish a list of provider types and designated
52.28 categorical risk levels in the Minnesota Health Care Program Provider Manual.

52.29 (b) The list and criteria are not subject to the requirements of chapter 14, and section
52.30 14.386 does not apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

54.10 (b) Providers must report all provider-controlled locations where direct services are
54.11 provided to the commissioner and obtain approval before billing for services provided at a
54.12 new location.

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

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

54.18 **Subd. 5. Site visits.** (a) As a condition of enrollment in medical assistance, the
54.19 commissioner shall require that a provider permit the Centers for Medicare and Medicaid
54.20 Services (CMS), CMS's agents, or CMS's designated contractors and the Department of
54.21 Human Services (DHS), DHS's agents, or DHS's designated contractors to conduct
54.22 unannounced site visits of any of a provider's enrolled locations.

54.23 (b) At a minimum, the commissioner must conduct the following site visits at each of
54.24 a provider's enrolled locations:

54.25 (1) pre-enrollment site visits for providers designated as moderate-risk or high-risk under
54.26 subdivision 1;

54.27 (2) postenrollment site visits for providers designated as moderate-risk or high-risk under
54.28 subdivision 1; and

54.29 (3) unannounced site visits, as follows:

54.30 (i) prior to payment of the provider's first claim after enrollment, when required under
54.31 federal law or due to program integrity concerns;

54.32 (ii) within 12 months after the provider begins to bill claims; and

55.1 (iii) prior to revalidation under section 256B.0441, subdivision 3.

55.2 (c) The commissioner may conduct additional announced or unannounced site visits
55.3 when necessary to verify compliance with enrollment requirements or to protect program
55.4 integrity.

55.5 (d) A provider's failure to permit a required site visit is grounds for denial, suspension,
55.6 or termination of enrollment and may result in denial of claims or recoupment of payments.

55.7 Subd. 6. **Surety bonds.** (a) The commissioner must require a provider to purchase a
55.8 surety bond as a condition of initial enrollment, reenrollment, revalidation, reinstatement,
55.9 or continued enrollment if:

55.10 (1) the provider fails to demonstrate financial viability;

55.11 (2) the commissioner determines there is significant evidence of or potential for fraud
55.12 and abuse by the provider; or

55.13 (3) the provider or category of providers is designated high-risk pursuant to subdivision
55.14 1.

55.15 (b) The surety bond must be in an amount of \$100,000 or ten percent of the provider's
55.16 payments from Medicaid during the immediately preceding 12 months, whichever is greater.
55.17 The surety bond must name DHS as an obligee and must allow for recovery of costs and
55.18 fees in pursuing a claim on the bond.

55.19 (c) This subdivision does not apply if the provider currently maintains a surety bond
55.20 under the requirements in section 256B.051, 256B.0659, 256B.0701, or 256B.85.

55.21 Subd. 7. **Financial capacity.** As a condition of enrolling in medical assistance, the
55.22 commissioner must require, in a form and manner prescribed by the commissioner, that a
55.23 provider demonstrate sufficient financial capacity to operate, repay improper payments,
55.24 and make payroll for 90 days.

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

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

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

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

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

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

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

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

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

56.18 Subd. 9. **Incomplete provider enrollment applications.** The commissioner must deny
56.19 a provider's incomplete enrollment application if a provider fails to respond to the
56.20 commissioner's request for additional information within 60 days of the request.

56.21 Subd. 10. **Correspondence and notification.** The commissioner must deliver
56.22 correspondence and notifications, including notifications of termination and other actions,
56.23 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to
56.24 correspondences and notifications related to background studies.

56.25 Sec. 7. **[256B.0441] PROVIDER REVALIDATION.**

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

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

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

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

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

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

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

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

57.10 (1) provide 30-day notice to the provider of the provider's revalidation due date, including
57.11 instructions for revalidation, a list of materials the provider must submit, and a notice about
57.12 the unannounced site visit required under paragraph (b);

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

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

57.21 (b) The commissioner must conduct unannounced site visits at each of a provider's
57.22 enrolled locations under section 256B.044, subdivision 4, no more than 30 days prior to the
57.23 provider's revalidation due date.

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

57.26 Sec. 8. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
57.27 **TERMINATIONS.**

57.28 Subdivision 1. **Suspension of billing privileges.** (a) If a provider fails to comply with
57.29 any individual provider requirement or condition of participation, the commissioner must
57.30 suspend the provider's ability to bill until the provider comes into compliance.

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

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

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

58.8 **Subd. 2. Revocation for lack of documentation.** (a) The commissioner may revoke
58.9 the enrollment of an ordering or rendering provider for a period of not more than one year
58.10 if the provider fails to maintain and, upon request from the commissioner, provide access
58.11 to documentation relating to written orders or requests for payment for durable medical
58.12 equipment, certifications for home health services, or referrals for other items or services
58.13 written or ordered by the provider when the commissioner has identified a pattern of a lack
58.14 of documentation. A pattern means a failure to maintain documentation or provide access
58.15 to documentation on more than one occasion.

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

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

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

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

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

59.1 (4) the provider, or an individual with an ownership or control interest or who is an agent
59.2 or managing employee of the provider, fails to submit timely or accurate information, unless
59.3 the commissioner determines that termination or denial of enrollment is not in the best
59.4 interests of the medical assistance program and the commissioner documents that
59.5 determination in writing;

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

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

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

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

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

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

59.24 (3) serves primarily a pediatric population.

59.25 **Sec. 9. [256B.0443] PROVIDER PAYMENT WITHHOLDS.**

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

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

60.1 Sec. 10. **[256B.0444] ENROLLMENT MORATORIUM FOR HIGH-RISK**
60.2 **PROVIDERS.**

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

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

60.13 Subd. 2. **Continued enrollment of new clients.** Nothing in this section prohibits an
60.14 enrolled provider subject to a moratorium under this section from enrolling new clients or
60.15 beneficiaries during the period of the enrollment moratorium.

60.16 Subd. 3. **Notice.** At least ten days prior to issuing an enrollment moratorium under this
60.17 section, the commissioner must notify enrolled providers within the affected category and
60.18 the chairs and ranking minority members of the legislative committees with jurisdiction
60.19 over health and human services about the actions the commissioner plans to take under this
60.20 section. The notice must:

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

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

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

60.24 Subd. 4. **Report to legislature.** Within 60 days of ending an enrollment moratorium
60.25 under this section, the commissioner must submit a report to the chairs and ranking minority
60.26 members of the legislative committees with jurisdiction over health and human services.
60.27 The report must include, at a minimum:

60.28 (1) a summary of any sanctions imposed under section 256B.064 on any providers subject
60.29 to the moratorium; and

60.30 (2) recommendations for modifying or terminating the provision of covered services
60.31 delivered by provider types subject to the moratorium.

61.1 Sec. 11. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
61.2 **FOR SPECIFIC PROVIDER TYPES.**

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

61.8 (b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable
61.9 medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable
61.10 medical equipment provider or supplier definition in paragraph (a), operating in Minnesota,
61.11 and receiving medical assistance money must purchase a surety bond that is annually
61.12 renewed, designates the state agency as the obligee, and is submitted in a form approved
61.13 by the commissioner. For purposes of this paragraph, the following medical suppliers are
61.14 not required to obtain a surety bond: a federally qualified health center, a home health
61.15 agency, the Indian Health Service, a pharmacy, and a rural health clinic.

61.16 (c) At the time of initial enrollment or reenrollment, durable medical equipment providers
61.17 or suppliers defined in paragraph (a) must purchase a surety bond of \$50,000. If a revalidating
61.18 provider's medical assistance revenue in the previous calendar year is up to and including
61.19 \$300,000, the provider agency must purchase a surety bond of \$50,000. If a revalidating
61.20 provider's medical assistance revenue in the previous calendar year is over \$300,000, the
61.21 provider agency must purchase a surety bond of \$100,000. The surety bond must allow for
61.22 recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary
61.23 recovery or sanctions from a surety bond must occur within six years from the date the debt
61.24 is affirmed by a final agency decision. An agency decision is final when the right to appeal
61.25 the debt has been exhausted or the time to appeal has expired under section 256B.064.

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

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

62.1 Sec. 12. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is
62.2 amended to read:

62.3 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
62.4 be increased for services provided to medical assistance enrollees. To receive a rate increase,
62.5 participating providers must meet demonstration project requirements and provide evidence
62.6 of formal referral arrangements with providers delivering step-up or step-down levels of
62.7 care. Providers that have enrolled in the demonstration project but have not met the provider
62.8 standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under
62.9 this subdivision until the date that the provider meets the provider standards in subdivision
62.10 3. Services provided from July 1, 2022, to the date that the provider meets the provider
62.11 standards under subdivision 3 shall be reimbursed at rates according to section 254B.0505,
62.12 subdivision 1. Rate increases paid under this subdivision to a provider for services provided
62.13 between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider
62.14 is taking meaningful steps to meet demonstration project requirements that are not otherwise
62.15 required by law, and the provider provides documentation to the commissioner, upon request,
62.16 of the steps being taken.

62.17 (b) The commissioner may temporarily suspend payments to the provider according to
62.18 section ~~256B.04, subdivision 21, paragraph (d)~~ 256B.0442, subdivision 1, if the provider
62.19 does not meet the requirements in paragraph (a). Payments withheld from the provider must
62.20 be made once the commissioner determines that the requirements in paragraph (a) are met.

62.21 (c) For outpatient individual and group substance use disorder services under section
62.22 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed
62.23 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
62.24 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in
62.25 effect on December 31, 2020.

62.26 (d) Effective January 1, 2021, and contingent on annual federal approval, managed care
62.27 plans and county-based purchasing plans must reimburse providers of the substance use
62.28 disorder services meeting the criteria described in paragraph (a) who are employed by or
62.29 under contract with the plan an amount that is at least equal to the fee-for-service base rate
62.30 payment for the substance use disorder services described in paragraph (c). The commissioner
62.31 must monitor the effect of this requirement on the rate of access to substance use disorder
62.32 services and residential substance use disorder rates. Capitation rates paid to managed care
62.33 organizations and county-based purchasing plans must reflect the impact of this requirement.
62.34 This paragraph expires if federal approval is not received at any time as required under this
62.35 paragraph.

63.1 (e) Effective July 1, 2021, contracts between managed care plans and county-based
63.2 purchasing plans and providers to whom paragraph (d) applies must allow recovery of
63.3 payments from those providers if, for any contract year, federal approval for the provisions
63.4 of paragraph (d) is not received, and capitation rates are adjusted as a result. Payment
63.5 recoveries must not exceed the amount equal to any decrease in rates that results from this
63.6 provision.

63.7 (f) For substance use disorder services with medications for opioid use disorder under
63.8 section 254B.0505, subdivision 1, clause (7), provided on or after January 1, 2021, payment
63.9 rates must be increased by 20 percent over the rates in effect on December 31, 2020. Upon
63.10 implementation of new rates according to section 254B.121, the 20 percent increase will
63.11 no longer apply.

63.12 Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
63.13 amended to read:

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

63.16 (1) enroll as a medical assistance Minnesota health care program provider according to
63.17 Minnesota Rules, part 9505.0195, and ~~section 256B.04, subdivision 21~~ sections 256B.044
63.18 to 256B.0445, and meet all applicable provider standards and requirements;

63.19 (2) designate an individual as the agency's compliance officer who must perform the
63.20 duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision
63.21 8, paragraph (b);

63.22 (3) demonstrate compliance with federal and state laws for the delivery of and billing
63.23 for EIDBI service;

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

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

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

64.1 services, appropriately submit claims, conduct required staff training, document staff
64.2 qualifications, document service activities, and document service quality;

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

64.4 (8) initiate a background study as required under subdivision 16a;

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

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

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

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

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

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

64.23 (15) provide clinical supervision for a minimum of one hour for every 16 hours of direct
64.24 treatment per person, unless otherwise authorized in the person's individual treatment plan;
64.25 and

64.26 (16) provide required EIDBI intervention observation and direction at least once per
64.27 month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention
64.28 observation and direction under this clause may be conducted via telehealth provided that
64.29 no more than two consecutive monthly required EIDBI intervention observation and direction
64.30 sessions under this clause are conducted via telehealth.

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

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

65.3 (2) provide disclosures of the use of billing agencies and other consultants who do not
65.4 provide EIDBI services; and

65.5 (3) provide copies of any contracts with consultants or independent contractors who do
65.6 not provide EIDBI services, including hours contracted and responsibilities.

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

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

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

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

65.17 Sec. 14. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

65.18 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the
65.19 Early Intensive Developmental and Behavioral Intervention Advisory Council and
65.20 stakeholders, including agencies, professionals, parents of people with ASD or a related
65.21 condition, and advocacy organizations, the commissioner shall determine if a shortage of
65.22 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"
65.23 means a lack of availability of providers who meet the EIDBI provider qualification
65.24 requirements under subdivision 15 that results in the delay of access to timely services under
65.25 this section, or that significantly impairs the ability of a provider agency to have sufficient
65.26 providers to meet the requirements of this section. The commissioner shall consider
65.27 geographic factors when determining the prevalence of a shortage. The commissioner may
65.28 determine that a shortage exists only in a specific region of the state, multiple regions of
65.29 the state, or statewide. The commissioner shall also consider the availability of various types
65.30 of treatment modalities covered under this section.

65.31 (b) The commissioner, in consultation with the Early Intensive Developmental and
65.32 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
65.33 criteria for granting an exception under this paragraph. The commissioner may grant an

66.1 exception only if the exception would not compromise a person's safety and not diminish
 66.2 the effectiveness of the treatment. The commissioner may establish an expiration date for
 66.3 an exception granted under this paragraph. The commissioner may grant an exception for
 66.4 the following:

66.5 (1) EIDBI provider qualifications under this section;

66.6 (2) medical assistance provider enrollment requirements under ~~section 256B.04,~~
 66.7 ~~subdivision 21~~ sections 256B.044 to 256B.0445; or

66.8 (3) EIDBI provider or agency standards or requirements.

66.9 (c) If the commissioner, in consultation with the Early Intensive Developmental and
 66.10 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no
 66.11 longer exists, the commissioner must submit a notice that a shortage no longer exists to the
 66.12 chairs and ranking minority members of the senate and the house of representatives
 66.13 committees with jurisdiction over health and human services. The commissioner must post
 66.14 the notice for public comment for 30 days. The commissioner shall consider public comments
 66.15 before submitting to the legislature a request to end the shortage declaration. The
 66.16 commissioner shall not declare the shortage of EIDBI providers ended without direction
 66.17 from the legislature to declare it ended.

66.18 ARTICLE 5

66.19 AGING AND DISABILITY SERVICES POLICY

66.20 Section 1. Minnesota Statutes 2024, section 245A.03, subdivision 7, is amended to read:

66.21 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
 66.22 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, which
 66.23 does not include child foster residence settings with residential program certifications for
 66.24 compliance with the Family First Prevention Services Act under section 245A.25, subdivision
 66.25 1, paragraph (a), or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
 66.26 9555.6265, under this chapter for a physical location that will not be the primary residence
 66.27 of the license holder for the entire period of licensure. If a child foster residence setting that
 66.28 was previously exempt from the licensing moratorium under this paragraph has its Family
 66.29 First Prevention Services Act certification rescinded under section 245A.25, subdivision 9,
 66.30 or if a family adult foster care home license is issued during this moratorium, and the license
 66.31 holder changes the license holder's primary residence away from the physical location of
 66.32 the foster care license, the commissioner shall revoke the license according to section
 66.33 245A.07. The commissioner shall not issue an initial license for a community residential

67.1 setting licensed under chapter 245D. When approving an exception under this paragraph,
 67.2 the commissioner shall consider the resource need determination process in paragraph (h),
 67.3 the availability of foster care licensed beds in the geographic area in which the licensee
 67.4 seeks to operate, the results of a person's choices during their annual assessment and service
 67.5 plan review, and the recommendation of the local county board. The determination by the
 67.6 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

67.7 (1) a license for a person in a foster care setting that is not the primary residence of the
 67.8 license holder and where at least 80 percent of the residents are 55 years of age or older;

67.9 ~~(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or~~
 67.10 ~~community residential setting licenses replacing adult foster care licenses in existence on~~
 67.11 ~~December 31, 2013, and determined to be needed by the commissioner under paragraph~~
 67.12 ~~(b);~~

67.13 ~~(3)~~ (2) new foster care licenses or community residential setting licenses determined to
 67.14 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
 67.15 ICF/DD, or regional treatment center; restructuring of state-operated services that limits
 67.16 the capacity of state-operated facilities; or allowing movement to the community for people
 67.17 who no longer require the level of care provided in state-operated facilities as provided
 67.18 under section 256B.092, subdivision 13, or 256B.49, subdivision 24; or

67.19 ~~(4)~~ (3) new foster care licenses or community residential setting licenses determined to
 67.20 be needed by the commissioner under paragraph (b) for persons requiring hospital-level
 67.21 care; ~~or.~~

67.22 ~~(5) new community residential setting licenses determined necessary by the commissioner~~
 67.23 ~~for people affected by the closure of homes with a capacity of five or six beds currently~~
 67.24 ~~licensed as supervised living facilities licensed under Minnesota Rules, chapter 4665, but~~
 67.25 ~~not designated as intermediate care facilities. This exception is available until June 30, 2025.~~

67.26 (b) The commissioner shall determine the need for newly licensed foster care homes or
 67.27 community residential settings as defined under this subdivision. As part of the determination,
 67.28 the commissioner shall consider the availability of foster care capacity in the area in which
 67.29 the licensee seeks to operate, and the recommendation of the local county board. The
 67.30 determination by the commissioner must be final. A determination of need is not required
 67.31 for a change in ownership at the same address.

67.32 (c) When an adult resident served by the program moves out of a foster home that is not
 67.33 the primary residence of the license holder according to section 256B.49, subdivision 15,
 67.34 paragraph (f), or the adult community residential setting, the county shall immediately

68.1 inform the Department of Human Services Licensing Division. The department may decrease
68.2 the statewide licensed capacity for adult foster care settings.

68.3 (d) Residential settings that would otherwise be subject to the decreased license capacity
68.4 established in paragraph (c) must be exempt if the license holder's beds are occupied by
68.5 residents whose primary diagnosis is mental illness and the license holder is certified under
68.6 the requirements in subdivision 6a or section 245D.33.

68.7 (e) A resource need determination process, managed at the state level, using the available
68.8 data required by section 144A.351, and other data and information must be used to determine
68.9 where the reduced capacity determined under section 256B.493 will be implemented. The
68.10 commissioner shall consult with the stakeholders described in section 144A.351, and employ
68.11 a variety of methods to improve the state's capacity to meet the informed decisions of those
68.12 people who want to move out of corporate foster care or community residential settings,
68.13 long-term service needs within budgetary limits, including seeking proposals from service
68.14 providers or lead agencies to change service type, capacity, or location to improve services,
68.15 increase the independence of residents, and better meet needs identified by the long-term
68.16 services and supports reports and statewide data and information.

68.17 (f) At the time of application and reapplication for licensure, the applicant and the license
68.18 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
68.19 required to inform the commissioner whether the physical location where the foster care
68.20 will be provided is or will be the primary residence of the license holder for the entire period
68.21 of licensure. If the primary residence of the applicant or license holder changes, the applicant
68.22 or license holder must notify the commissioner immediately. The commissioner shall print
68.23 on the foster care license certificate whether or not the physical location is the primary
68.24 residence of the license holder.

68.25 (g) License holders of foster care homes identified under paragraph (f) that are not the
68.26 primary residence of the license holder and that also provide services in the foster care home
68.27 that are covered by a federally approved home and community-based services waiver, as
68.28 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
68.29 services licensing division that the license holder provides or intends to provide these
68.30 waiver-funded services.

68.31 (h) The commissioner may adjust capacity to address needs identified in section
68.32 144A.351. Under this authority, the commissioner may approve new licensed settings or
68.33 delicense existing settings. Delicensing of settings will be accomplished through a process
68.34 identified in section 256B.493.

69.1 (i) The commissioner must notify a license holder when its corporate foster care or
69.2 community residential setting licensed beds are reduced under this section. The notice of
69.3 reduction of licensed beds must be in writing and delivered to the license holder by certified
69.4 mail or personal service. The notice must state why the licensed beds are reduced and must
69.5 inform the license holder of its right to request reconsideration by the commissioner. The
69.6 license holder's request for reconsideration must be in writing. If mailed, the request for
69.7 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
69.8 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
69.9 reconsideration is made by personal service, it must be received by the commissioner within
69.10 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

69.11 (j) The commissioner shall not issue an initial license for children's residential treatment
69.12 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
69.13 for a program that Centers for Medicare and Medicaid Services would consider an institution
69.14 for mental diseases. Facilities that serve only private pay clients are exempt from the
69.15 moratorium described in this paragraph. The commissioner has the authority to manage
69.16 existing statewide capacity for children's residential treatment services subject to the
69.17 moratorium under this paragraph and may issue an initial license for such facilities if the
69.18 initial license would not increase the statewide capacity for children's residential treatment
69.19 services subject to the moratorium under this paragraph.

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

69.21 Sec. 2. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 2, is amended
69.22 to read:

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

69.28 (1) ethical considerations;

69.29 (2) functional assessment;

69.30 (3) functional analysis;

69.31 (4) measurement of behavior and interpretation of data;

69.32 (5) selecting intervention outcomes and strategies;

- 70.1 (6) behavior reduction and elimination strategies that promote least restrictive approved
70.2 alternatives;
- 70.3 (7) data collection;
- 70.4 (8) staff and caregiver training;
- 70.5 (9) support plan monitoring;
- 70.6 (10) co-occurring mental disorders or neurocognitive disorder;
- 70.7 (11) demonstrated expertise with populations being served; and
- 70.8 (12) must be a:
- 70.9 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
70.10 of Psychology competencies in the above identified areas;
- 70.11 (ii) clinical social worker licensed as an independent clinical social worker under chapter
70.12 148E, or a person with a master's degree in social work from an accredited college or
70.13 university, with at least 4,000 hours of post-master's supervised experience in the delivery
70.14 of clinical services in the areas identified in clauses (1) to (11);
- 70.15 (iii) physician licensed under chapter 147 and certified by the American Board of
70.16 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
70.17 in the areas identified in clauses (1) to (11);
- 70.18 (iv) licensed professional clinical counselor licensed under sections ~~148B.29 to 148B.39~~
70.19 148B.5301 and 148B.532 with at least 4,000 hours of post-master's supervised experience
70.20 in the delivery of clinical services who has demonstrated competencies in the areas identified
70.21 in clauses (1) to (11);
- 70.22 (v) person with a master's degree from an accredited college or university in one of the
70.23 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised
70.24 experience in the delivery of clinical services with demonstrated competencies in the areas
70.25 identified in clauses (1) to (11);
- 70.26 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
70.27 fields with demonstrated expertise in positive support services, as determined by the person's
70.28 needs as outlined in the person's assessment summary;
- 70.29 (vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is
70.30 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
70.31 mental health nursing by a national nurse certification organization, or who has a master's
70.32 degree in nursing or one of the behavioral sciences or related fields from an accredited

71.1 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
71.2 experience in the delivery of clinical services; or
71.3 (viii) person who has completed a competency-based training program as determined
71.4 by the commissioner.

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

71.6 Sec. 3. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 3, is amended
71.7 to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

72.14 Sec. 4. Minnesota Statutes 2024, section 256.9752, as amended by Laws 2025, First Special
 72.15 Session chapter 9, article 1, sections 6 and 7, is amended to read:

72.16 **256.9752 SENIOR NUTRITION PROGRAMS.**

72.17 Subdivision 1. **Program goals.** It is the goal of all area agencies on aging and senior
 72.18 nutrition programs to support the physical and mental health of ~~seniors~~ older adults living
 72.19 in the community by:

72.20 (1) promoting nutrition programs that serve ~~senior citizens~~ older adults in their homes
 72.21 and communities; ~~and~~

72.22 (2) providing, within the limit of funds available, the support services that will enable
 72.23 ~~the senior citizen~~ each older adult to access nutrition programs in the most cost-effective
 72.24 and efficient manner; and

72.25 (3) coordinating with health and long-term care systems, emergency preparedness
 72.26 systems, and other systems and stakeholders that support the health and wellness of older
 72.27 adults.

72.28 Subd. 1a. **Food delivery support account; appropriation.** (a) A food delivery support
 72.29 account is established in the special revenue fund. The account consists of funds under
 72.30 section 174.49, subdivision 2, and as provided by law and any other money donated, allotted,
 72.31 transferred, or otherwise provided to the account.

73.1 (b) Money in the account is annually appropriated to the commissioner of human services
 73.2 for grants to nonprofit organizations to provide transportation of home-delivered meals,
 73.3 groceries, purchased food, or a combination, to Minnesotans who are experiencing food
 73.4 insecurity and have difficulty obtaining or preparing meals due to limited mobility, disability,
 73.5 age, or resources to prepare their own meals. A nonprofit organization must have a
 73.6 demonstrated history of providing and distributing food customized for the population that
 73.7 they serve.

73.8 (c) Grant funds under this subdivision must supplement, but not supplant, any state or
 73.9 federal funding used to provide prepared meals to Minnesotans experiencing food insecurity.

73.10 Subd. 2. **Authority.** The Minnesota Board on Aging shall allocate to area agencies on
 73.11 aging the state nutrition support and food delivery support funds and the federal funds which
 73.12 that are received for the senior nutrition programs of congregate dining and home-delivered
 73.13 meals in a manner consistent with the board's intrastate funding formula.

73.14 Subd. 3. **Nutrition support services.** (a) Funds allocated to an area agency on aging
 73.15 for nutrition support services may be used for the following, as determined appropriate by
 73.16 the area agency on aging to address the needs of older adults in the agency's planning and
 73.17 service area:

73.18 (1) transportation of home-delivered meals and purchased food and medications to the
 73.19 residence of ~~a senior citizen~~ an older adult;

73.20 (2) expansion of home-delivered meals into unserved and underserved areas;

73.21 (3) transportation of older adults to supermarkets grocery stores or delivery of groceries
 73.22 ~~from supermarkets~~ to homes of older adults;

73.23 (4) vouchers for food purchases at selected restaurants in isolated rural areas;

73.24 (5) the Supplemental Nutrition Assistance Program (SNAP) outreach;

73.25 (6) transportation of ~~seniors~~ older adults to congregate dining sites;

73.26 (7) nutrition screening assessments and counseling as needed by individuals with special
 73.27 dietary needs, performed by a licensed dietitian or nutritionist;

73.28 (8) medically tailored meals;

73.29 ~~(8)~~ (9) other appropriate services which and tools that support senior nutrition programs,
 73.30 including new service delivery models and technology; and

73.31 ~~(9)~~ (10) development and implementation of innovative models of providing to provide
 73.32 healthy and nutritious meals to seniors food to older adults, including through partnerships

74.1 with schools, restaurants, hospitals, food shelves and food pantries, farmers, and other
74.2 community partners.

74.3 (b) An area agency on aging may transfer unused funding for nutrition support services
74.4 to fund congregate dining services and home-delivered meals.

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

74.7 Sec. 5. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision
74.8 to read:

74.9 Subd. 77. **Early intensive developmental and behavioral intervention benefit.** Medical
74.10 assistance covers early intensive developmental and behavioral intervention services
74.11 according to section 256B.0949.

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

74.13 Sec. 6. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 13, is
74.14 amended to read:

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

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

74.20 (1) have at least an associate's degree in human services, or other closely related field;

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

74.23 (3) be a registered nurse.

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

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

74.28 (e) A Tribal Nation may establish the Tribal Nation's own education and experience
74.29 qualifications for certified assessors.

75.1 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
75.2 whichever is later.

75.3 Sec. 7. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

75.4 Subd. 32. **Administrative activity.** (a) The commissioner shall:

75.5 (1) streamline the processes, including timelines for when assessments need to be
75.6 completed;

75.7 (2) provide the services in this section; and

75.8 (3) implement integrated solutions to automate the business processes to the extent
75.9 necessary for support plan approval, reimbursement, program planning, evaluation, and
75.10 policy development.

75.11 (b) The commissioner shall work with lead agencies responsible for conducting long-term
75.12 care consultation services to:

75.13 ~~(1) modify the MnCHOICES application and assessment policies to create efficiencies~~
75.14 ~~while ensuring federal compliance with medical assistance and long-term services and~~
75.15 ~~supports eligibility criteria; and.~~

75.16 ~~(2) develop a set of measurable benchmarks sufficient to demonstrate quarterly~~
75.17 ~~improvement in the average time per assessment and other mutually agreed upon measures~~
75.18 ~~of increasing efficiency.~~

75.19 ~~(c) The commissioner shall collect data on the benchmarks developed under paragraph~~
75.20 ~~(b) and provide to the lead agencies an annual trend analysis of the data in order to~~
75.21 ~~demonstrate the commissioner's compliance with the requirements of this subdivision.~~

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

75.23 Sec. 8. Minnesota Statutes 2024, section 256B.0924, subdivision 3, is amended to read:

75.24 Subd. 3. **Eligibility.** Persons are eligible to receive targeted case management services
75.25 under this section if the requirements in paragraphs (a) and (b) are met.

75.26 (a) The person must be assessed and determined by the local county or Tribal agency
75.27 to:

75.28 (1) be age 18 or older;

75.29 (2) be receiving medical assistance;

75.30 (3) have significant functional limitations; and

76.1 (4) be in need of service coordination to attain or maintain living in an integrated
76.2 community setting.

76.3 (b) Except as permitted under paragraph (c), the person must be: (1) a vulnerable adult
76.4 in need of adult protection as defined in section 626.5572, or is; (2) an adult with a
76.5 developmental disability as defined in section 252A.02, subdivision 2, or; (3) an adult with
76.6 a related condition as defined in section 256B.02, subdivision 11, and who is not receiving
76.7 home and community-based waiver services; or is (4) an adult who lacks a permanent
76.8 residence and who has been without a permanent residence for at least one year or on at
76.9 least four occasions in the last three years.

76.10 (c) Tribal agencies may make a determination of eligibility under Tribal governance
76.11 codes for adult protection or policy procedures consistent with section 626.5572 when
76.12 determining whether a person is a vulnerable adult in need of adult protection or an adult
76.13 with developmental disabilities or a related condition.

76.14 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
76.15 whichever is later.

76.16 Sec. 9. Minnesota Statutes 2024, section 256B.0924, subdivision 5, is amended to read:

76.17 Subd. 5. **Provider standards.** County boards ~~or~~, providers who contract with the county,
76.18 or Tribal government contracted providers are eligible to receive medical assistance
76.19 reimbursement for adult targeted case management services. To qualify as a provider of
76.20 targeted case management services the vendor must:

76.21 (1) have demonstrated the capacity and experience to provide the activities of case
76.22 management services defined in subdivision 4;

76.23 (2) be able to coordinate and link community resources needed by the recipient;

76.24 (3) have the administrative capacity and experience to serve the eligible population in
76.25 providing services and to ensure quality of services under state and federal requirements;

76.26 (4) have a financial management system that provides accurate documentation of services
76.27 and costs under state and federal requirements;

76.28 (5) have the capacity to document and maintain individual case records complying with
76.29 state and federal requirements;

76.30 (6) coordinate with county social ~~service~~ services or Tribal human services agencies
76.31 responsible for planning for community social services under chapters 256E and 256F;

77.1 conducting adult protective investigations under section 626.557, and conducting prepetition
77.2 screenings for commitments under section 253B.07;

77.3 (7) coordinate with health care providers to ensure access to necessary health care
77.4 services;

77.5 (8) have a procedure in place that notifies the recipient and the recipient's legal
77.6 representative of any conflict of interest if the contracted targeted case management service
77.7 provider also provides the recipient's services and supports and provides information on all
77.8 potential conflicts of interest and obtains the recipient's informed consent and provides the
77.9 recipient with alternatives; and

77.10 (9) have demonstrated the capacity to achieve the following performance outcomes:
77.11 access, quality, and consumer satisfaction.

77.12 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
77.13 whichever is later.

77.14 Sec. 10. Minnesota Statutes 2024, section 256B.0924, is amended by adding a subdivision
77.15 to read:

77.16 **Subd. 5a. Tribal case manager qualifications.** An individual is authorized to serve as
77.17 a vulnerable adult and developmental disability targeted case manager if the individual is
77.18 certified by a federally recognized Tribal government in Minnesota pursuant to section
77.19 256B.02, subdivision 7, paragraph (c).

77.20 Sec. 11. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is
77.21 amended to read:

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

77.30 (b) Except as provided under paragraph (m), payment for targeted case management
77.31 provided by county staff under this subdivision shall be based on the monthly rate
77.32 methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one

78.1 combined average rate together with adult mental health case management under section
78.2 256B.0625, subdivision 20, ~~except for calendar year 2002. In calendar year 2002, the rate~~
78.3 ~~for case management under this section shall be the same as the rate for adult mental health~~
78.4 ~~case management in effect as of December 31, 2001.~~ Billing and payment must identify the
78.5 recipient's primary population group to allow tracking of revenues.

78.6 (c) Payment for targeted case management provided by county-contracted vendors shall
78.7 be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2.
78.8 Payment for case management provided by vendors who contract with a Tribe must be made
78.9 in accordance with Indian Health Service facility requirements. If a Tribe chooses to contract
78.10 with a vendor receiving payment not through an Indian Health Service facility, the rate must
78.11 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
78.12 by the vendor for the same service to other payers. If the service is provided by a team of
78.13 contracted vendors, the team shall determine how to distribute the rate among its members.
78.14 No reimbursement received by contracted vendors shall be returned to the county or Tribe,
78.15 except to reimburse the county or Tribe for advance funding provided by the county or
78.16 Tribe to the vendor.

78.17 (d) If the service is provided by a team that includes any combination of contracted
78.18 vendors ~~and~~, county staff, and Tribal staff, the costs for county staff participation on the
78.19 team shall be included in the rate for county-provided services. In this case, the contracted
78.20 vendor and the county and Tribal case managers may each receive separate payment for
78.21 services provided by each entity in the same month. In order to prevent duplication of
78.22 services, ~~the county~~ each entity must document, ~~in the recipient's file,~~ the need for team
78.23 targeted case management and a description of the different roles of ~~the team members~~ staff.

78.24 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
78.25 targeted case management shall be provided by the recipient's county of responsibility, as
78.26 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
78.27 used to match other federal funds. If the service is provided by a Tribal agency, the recipient's
78.28 Tribe must provide the nonfederal share of costs, if any.

78.29 (f) The commissioner may suspend, reduce, or terminate reimbursement to a provider
78.30 that does not meet the reporting or other requirements of this section. The county of
78.31 responsibility, as defined in sections 256G.01 to 256G.12, or Tribe when applicable, is
78.32 responsible for any federal disallowances. The county may share this responsibility with
78.33 its contracted vendors.

79.1 (g) The commissioner shall set aside five percent of the federal funds received under
79.2 this section for use in reimbursing the state for costs of developing and implementing this
79.3 section.

79.4 (h) Payments to counties and Tribes for targeted case management expenditures under
79.5 this section shall only be made from federal earnings from services provided under this
79.6 section. Payments to contracted vendors shall include both the federal earnings and the
79.7 county share.

79.8 (i) Notwithstanding section 256B.041, county or Tribal payments for the cost of case
79.9 management services provided by county or Tribal staff shall not be made to the
79.10 commissioner of management and budget. For the purposes of targeted case management
79.11 services provided by county or Tribal staff under this section, the centralized disbursement
79.12 of payments to counties or Tribes under section 256B.041 consists only of federal earnings
79.13 from services provided under this section.

79.14 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
79.15 and the recipient's institutional care is paid by medical assistance, payment for targeted case
79.16 management services under this subdivision is limited to the lesser of:

79.17 (1) the last 180 days of the recipient's residency in that facility; or

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

79.19 (k) Payment for targeted case management services under this subdivision shall not
79.20 duplicate payments made under other program authorities for the same purpose.

79.21 (l) Any growth in targeted case management services and cost increases under this
79.22 section shall be the responsibility of the counties or Tribes.

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

79.27 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
79.28 whichever is later.

79.29 Sec. 12. Minnesota Statutes 2024, section 256B.0924, subdivision 7, is amended to read:

79.30 Subd. 7. **Implementation and evaluation.** The commissioner of human services in
79.31 consultation with county boards and Tribal Nations shall establish a program to accomplish
79.32 the provisions of subdivisions 1 to 6. The commissioner in consultation with county boards

80.1 and Tribal Nations shall establish performance measures to evaluate the effectiveness of
80.2 the targeted case management services. If a county or Tribe fails to meet agreed-upon
80.3 performance measures, the commissioner may authorize contracted providers other than
80.4 the county or Tribe. Providers contracted by the commissioner shall also be subject to the
80.5 standards in subdivision 6.

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

80.7 Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 2, is
80.8 amended to read:

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

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

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

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

80.23 (1) is severe and chronic;

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

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

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

80.32 (i) behavioral challenges and self-regulation;

81.1 (ii) cognition;

81.2 (iii) learning and play;

81.3 (iv) self-care; or

81.4 (v) safety.

81.5 (e) "Behavior analyst" means an individual licensed under sections 148.9981 to 148.9995
81.6 as a behavior analyst.

81.7 (f) "Clinical supervision" means the overall responsibility for the control and direction
81.8 of EIDBI service delivery, including ~~individual treatment planning~~, staff supervision,
81.9 including observation and direction; individual treatment plan development and progress
81.10 monitoring; family training and counseling; and ~~treatment review~~ coordinated care
81.11 conference coordination for each person. Clinical supervision is provided by a qualified
81.12 supervising professional (QSP) who takes full professional responsibility for the service
81.13 provided by each supervisee and the clinical effectiveness of all interventions.

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

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

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

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

81.24 (k) "Employee of an agency" or "employee" means any individual who is employed
81.25 temporarily, part time, or full time by the agency that is submitting claims or billing for the
81.26 work, services, supervision, or treatment performed by the individual. Employee does not
81.27 include an independent contractor, billing agency, or consultant who is not providing EIDBI
81.28 services. Employee does not include an individual who performs work, provides services,
81.29 supervises, or provides treatment for less than 80 hours in a 12-month period.

81.30 (l) "Generalizable goals" means results or gains that are observed during a variety of
81.31 activities over time with different people, such as providers, family members, other adults,

82.1 and people, and in different environments including, but not limited to, clinics, homes,
82.2 schools, and the community.

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

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

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

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

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

82.12 (o) "Legal representative" means the parent of a child who is under 18 years of age, a
82.13 court-appointed guardian, or other representative with legal authority to make decisions
82.14 about service for a person. For the purpose of this subdivision, "other representative with
82.15 legal authority to make decisions" includes a health care agent or an attorney-in-fact
82.16 authorized through a health care directive or power of attorney.

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

82.19 (q) "Person" means an individual under 21 years of age.

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

82.24 (s) "Qualified EIDBI provider" means an individual who is a QSP or a level I, level II,
82.25 or level III treatment provider.

82.26 Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
82.27 amended to read:

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

- 83.1 (1) enroll as a medical assistance Minnesota health care program provider according to
83.2 Minnesota Rules, part 9505.0195, and section 256B.04, subdivision 21, and meet all
83.3 applicable provider standards and requirements;
- 83.4 (2) designate an individual as the agency's compliance officer who must perform the
83.5 duties described in section 256B.04, subdivision 21, paragraph (g);
- 83.6 (3) demonstrate compliance with federal and state laws for the delivery of and billing
83.7 for EIDBI service;
- 83.8 (4) verify and maintain records of a service provided to the person or the person's legal
83.9 representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;
- 83.10 (5) demonstrate that while enrolled or seeking enrollment as a Minnesota health care
83.11 program provider the agency did not have a lead agency contract or provider agreement
83.12 discontinued because of a conviction of fraud; or did not have an owner, board member, or
83.13 manager fail a state or federal criminal background check or appear on the list of excluded
83.14 individuals or entities maintained by the federal Department of Human Services Office of
83.15 Inspector General;
- 83.16 (6) have established business practices including written policies and procedures, internal
83.17 controls, and a system that demonstrates the organization's ability to deliver quality EIDBI
83.18 services, appropriately submit claims, conduct required staff training, document staff
83.19 qualifications, document service activities, and document service quality;
- 83.20 (7) have an office located in Minnesota or a border state;
- 83.21 (8) initiate a background study as required under subdivision 16a;
- 83.22 (9) report maltreatment according to section 626.557 and chapter 260E;
- 83.23 (10) comply with any data requests consistent with the Minnesota Government Data
83.24 Practices Act, sections 256B.064 and 256B.27;
- 83.25 (11) provide training for all agency staff on the requirements and responsibilities listed
83.26 in the Maltreatment of Minors Act, chapter 260E, and the Vulnerable Adult Protection Act,
83.27 section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's
83.28 policy for all staff on how to report suspected abuse and neglect;
- 83.29 (12) have a written policy to resolve issues collaboratively with the person and the
83.30 person's legal representative when possible. The policy must include a timeline for when
83.31 the person and the person's legal representative will be notified about issues that arise in
83.32 the provision of services;

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

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

84.8 (15) provide clinical supervision for a minimum of one hour for every 16 hours of direct
84.9 treatment per person, unless otherwise authorized in the person's individual treatment plan;
84.10 and

84.11 (16) provide the required EIDBI intervention observation and direction by a QSP at least
84.12 once per month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention
84.13 observation and direction under this clause may be conducted via telehealth provided that
84.14 no more than two consecutive monthly required EIDBI intervention observation and direction
84.15 sessions under this clause are conducted via telehealth.

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

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

84.20 (2) provide disclosures of the use of billing agencies and other consultants who do not
84.21 provide EIDBI services; and

84.22 (3) provide copies of any contracts with consultants or independent contractors who do
84.23 not provide EIDBI services, including hours contracted and responsibilities.

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

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

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

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

85.4 Sec. 15. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 18, is
85.5 amended to read:

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

85.12 (b) The commissioner may withhold payment from an agency or suspend or terminate
85.13 the agency's enrollment number if the agency fails to provide access to the agency's service
85.14 locations or records or fails to comply with documentation requirements under subdivision
85.15 19 or the commissioner determines the agency has failed to comply fully with applicable
85.16 laws or rules. The provider has the right to appeal the decision of the commissioner under
85.17 section 256B.064.

85.18 Sec. 16. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision
85.19 to read:

85.20 Subd. 19. **Documentation requirements.** (a) CMDE and EIDBI providers must ensure
85.21 that all documentation, including but not limited to health service records and personnel
85.22 files, complies with this subdivision, subdivision 16, and Minnesota Rules, parts 9505.2175
85.23 and 9505.2197. Documentation must be complete, legible, accurate, and readily accessible.

85.24 (b) All documentation must:

85.25 (1) be legible and understandable to individuals outside service delivery;

85.26 (2) include the participant's name on each health record page and the provider's name
85.27 on each personnel file page;

85.28 (3) be signed and dated by the provider completing the documentation with the provider's
85.29 full name, title, and credentials;

85.30 (4) be entered within 72 hours of service and contain a record and explanation of any
85.31 delays in entry;

- 86.1 (5) clearly reflect clinical decision-making and support medical necessity;
- 86.2 (6) be securely stored in accordance with the Health Insurance Portability and
- 86.3 Accountability Act (HIPAA), Public Law 104-191;
- 86.4 (7) be stored in accordance with state and federal document retention laws;
- 86.5 (8) be available for review or audit;
- 86.6 (9) include a record of caregiver involvement where applicable; and
- 86.7 (10) include a record of supervision and oversight for staff providing services requiring
- 86.8 supervision under EIDBI policy.
- 86.9 (c) Each EIDBI service occurrence must be documented in a progress note in a manner
- 86.10 and with the information determined by the commissioner.
- 86.11 (d) All providers must maintain current personnel records for each employee in a manner
- 86.12 determined by the commissioner that include:
- 86.13 (1) the employee's name, contact information, and hire date;
- 86.14 (2) the employee's completed employment application and acknowledgment of duties;
- 86.15 (3) the job description for the employee's job with the effective date;
- 86.16 (4) verification of the employee's qualifications, including but not limited to education,
- 86.17 licenses, certifications, enrollment attestation, degrees, transcripts, and experience;
- 86.18 (5) a background study pursuant to chapter 245C with a notice from the commissioner
- 86.19 that the subject of the study is:
- 86.20 (i) not disqualified under section 245C.14; or
- 86.21 (ii) disqualified but the subject of the study has received a set-aside of the disqualification
- 86.22 under section 245C.22;
- 86.23 (6) orientation and required training the employee attended, including but not limited
- 86.24 to training on mandated reporting, cultural responsiveness, and EIDBI competencies;
- 86.25 (7) the dates of the employee's first supervised and unsupervised client contact following
- 86.26 employment;
- 86.27 (8) documentation of supervision received by the employee, including but not limited
- 86.28 to the supervisor's name and credentials, dates of supervision, supervision content, and the
- 86.29 employee's signature indicating the accuracy of the documented supervision;
- 86.30 (9) the employee's CPR and emergency response training, if required; and

87.1 (10) the employee's annual performance evaluations.

87.2 (e) If an incident occurs or the person is injured while receiving services, the provider
87.3 must document what occurred and how staff responded to the incident.

87.4 Sec. 17. Minnesota Statutes 2024, section 256B.4905, subdivision 2a, is amended to read:

87.5 Subd. 2a. **Informed choice policy.** (a) It is the policy of this state that all adults who
87.6 have disabilities and, with support from their families or legal representatives, that all
87.7 children who have disabilities:

87.8 (1) may make informed choices to select and utilize disability services and supports;
87.9 and

87.10 (2) are offered an informed decision-making process sufficient to make informed choices.

87.11 (b) It is the policy of this state that disability waivers services support the presumption
87.12 that adults who have disabilities and, with support from their families or legal representatives,
87.13 all children who have disabilities may make informed choices; and that all adults who have
87.14 disabilities and all families of children who have disabilities and are accessing waiver
87.15 services under sections 256B.092 and 256B.49 are provided an informed decision-making
87.16 process that satisfies the requirements of subdivision 3a.

87.17 (c) Lead agencies must support individuals in making informed choices by:

87.18 (1) providing complete and accurate information about available home and
87.19 community-based services and settings;

87.20 (2) providing the information in a manner that is culturally and linguistically appropriate;
87.21 and

87.22 (3) facilitating access to services that reflect the individual's preferences and assessed
87.23 needs.

87.24 (d) For individuals who are members of or affiliated with a federally recognized Tribal
87.25 Nation located within Minnesota, informed choice includes the right to receive services
87.26 administered or provided by the individual's Tribal Nation. Lead agencies must:

87.27 (1) inform individuals of services offered by Tribal Nations enrolled as Minnesota health
87.28 care providers;

87.29 (2) directly coordinate with the individual's Tribal Nation human services agency when
87.30 the individual seeks or may be eligible for services administered or provided by that Tribal
87.31 Nation; and

88.1 (3) ensure that service planning and delivery respects the individual's rights as both a
88.2 member of a sovereign Tribal Nation and a resident of Minnesota.

88.3 (e) County lead agencies and Tribal Nation human services agencies must establish and
88.4 maintain procedures to share updated contact information, coordinate case management,
88.5 and provide timely referrals necessary to ensure that informed choice is fully exercised.

88.6 (f) Nothing in this section limits the sovereignty of Tribal Nations or the authority of
88.7 Tribal governments to administer home and community-based services to their members.

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

88.9 Sec. 18. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 8, is
88.10 amended to read:

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

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

88.18 (1) competitive workforce factor: 6.7 percent;

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

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

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

88.22 (5) program plan support ratio: 15.5 percent;

88.23 (6) client programming and support ratio: 4.7 percent, updated as specified in subdivision
88.24 5b;

88.25 (7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

89.24 (11) this is the subtotal rate;

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

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

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

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

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

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

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

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

90.11 (e) Effective January 1, ~~2026~~ 2027, or upon federal approval, whichever is later, a
90.12 provider must not bill more than ~~three consecutive hours and not more than six total hours~~
90.13 ~~per day~~ the monthly unit of service limit determined by multiplying 24 units by the total
90.14 number of days in each month for individualized home supports with training and not more
90.15 than six total hours per day for individualized home supports with family training. ~~This~~
90.16 ~~daily limit does~~ These limits do not:

90.17 (1) limit a person's use of other disability waiver services, including individualized home
90.18 supports, which may be provided on the same day by the same provider providing
90.19 individualized home supports with training or individualized home supports with family
90.20 training; or

90.21 (2) apply to individuals who meet the residential support services criteria under sections
90.22 256B.092, subdivision 11a, and 256B.49, subdivision 29.

90.23 Sec. 19. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 10a, is
90.24 amended to read:

90.25 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
90.26 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
90.27 service. As determined by the commissioner, in consultation with community partners
90.28 identified in subdivision 17, a provider enrolled to provide services with rates determined
90.29 under this section must submit requested cost data to the commissioner to support research
90.30 on the cost of providing services that have rates determined by the disability waiver rates
90.31 system. Requested cost data may include, but is not limited to:

90.32 (1) worker wage costs;

- 91.1 (2) benefits paid;
- 91.2 (3) supervisor wage costs;
- 91.3 (4) executive wage costs;
- 91.4 (5) vacation, sick, and training time paid;
- 91.5 (6) taxes, workers' compensation, and unemployment insurance costs paid;
- 91.6 (7) administrative costs paid;
- 91.7 (8) program costs paid;
- 91.8 (9) transportation costs paid;
- 91.9 (10) vacancy rates; and
- 91.10 (11) other data relating to costs required to provide services requested by the
- 91.11 commissioner.

91.12 (b) At least once in any five-year period, a provider must submit cost data for a fiscal

91.13 year that ended not more than 18 months prior to the submission date. The commissioner

91.14 shall provide each provider a 90-day notice prior to its submission due date. The

91.15 commissioner may review report submissions for inaccurate, inconclusive, incomplete, or

91.16 otherwise deficient data and may remove the report from submitted status for further

91.17 verification. If a provider fails to submit required reporting data, the commissioner shall

91.18 provide notice to providers that have not provided required data 30 days after the required

91.19 submission date, and a second notice for providers who have not provided required data 60

91.20 days after the required submission date. The commissioner shall temporarily suspend

91.21 payments to the provider if cost data is not received 90 days after the required submission

91.22 date. Withheld payments shall be made once data is received and reviewed for compliance

91.23 by the commissioner.

91.24 (c) The commissioner shall conduct a random validation of data submitted under

91.25 paragraph (a) to ensure data accuracy. Providers selected to validate cost reports must

91.26 respond to the commissioner within 30 days with the requested financial documentation. If

91.27 a provider fails to respond to the commissioner with all the requested information within

91.28 30 days, the commissioner must temporarily suspend payments. The commissioner must

91.29 resume payments once the requested documentation is received. If a provider is unable to

91.30 validate the provider's costs with supporting documentation, the commissioner must require

91.31 the provider to participate in the random validation the next year that the commissioner

92.1 selects providers to report their costs. The commissioner shall analyze cost documentation
92.2 in paragraph (a) and provide recommendations for adjustments to cost components.

92.3 (d) The commissioner shall analyze cost data submitted under paragraph (a). The
92.4 commissioner shall release cost data in an aggregate form. Cost data from individual
92.5 providers must not be released except as provided for in current law.

92.6 (e) Beginning January 1, 2029, the commissioner shall use data collected in paragraph
92.7 (a) to determine the compliance with requirements identified under subdivision 10d. The
92.8 commissioner shall identify providers who have not met the thresholds identified under
92.9 subdivision 10d on the Department of Human Services website for the year for which the
92.10 providers reported their costs.

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

92.12 Sec. 20. Minnesota Statutes 2024, section 256B.851, subdivision 8, is amended to read:

92.13 Subd. 8. **Personal care provider agency; required reporting of cost data; training.** (a)
92.14 As determined by the commissioner and in consultation with stakeholders, agencies enrolled
92.15 to provide services with rates determined under this section must submit requested cost data
92.16 to the commissioner. The commissioner may request cost data, including but not limited
92.17 to:

92.18 (1) worker wage costs;

92.19 (2) benefits paid;

92.20 (3) supervisor wage costs;

92.21 (4) executive wage costs;

92.22 (5) vacation, sick, and training time paid;

92.23 (6) taxes, workers' compensation, and unemployment insurance costs paid;

92.24 (7) administrative costs paid;

92.25 (8) program costs paid;

92.26 (9) transportation costs paid;

92.27 (10) staff vacancy rates; and

92.28 (11) other data relating to costs required to provide services requested by the
92.29 commissioner.

93.1 (b) At least once in any three-year period, a provider must submit the required cost data
93.2 for a fiscal year that ended not more than 18 months prior to the submission date. The
93.3 commissioner must provide each provider a 90-day notice prior to its submission due date.
93.4 The commissioner may review report submissions for inaccurate, inconclusive, incomplete,
93.5 or otherwise deficient data and may remove the report from submitted status for further
93.6 verification. If a provider fails to submit required cost data, the commissioner must provide
93.7 notice to a provider that has not provided required cost data 30 days after the required
93.8 submission date and a second notice to a provider that has not provided required cost data
93.9 60 days after the required submission date. The commissioner must temporarily suspend
93.10 payments to a provider if the commissioner has not received required cost data 90 days after
93.11 the required submission date. The commissioner must make withheld payments when the
93.12 required cost data is received and reviewed for compliance by the commissioner.

93.13 (c) The commissioner must conduct a random validation of data submitted under this
93.14 subdivision to ensure data accuracy. A provider selected to validate the provider's cost
93.15 reports must respond to the commissioner within 30 days with the requested financial
93.16 documentation. If a provider fails to respond to the commissioner with the requested
93.17 information within 30 days, the commissioner must temporarily suspend payments. The
93.18 commissioner must resume payments once the requested documentation is received. If a
93.19 provider is unable to validate the provider's costs with supporting documentation, the
93.20 commissioner must require the provider to participate in the random validation the next
93.21 year that the commissioner selects providers to report their costs. The commissioner shall
93.22 analyze cost documentation in paragraph (a) and provide recommendations for adjustments
93.23 to cost components.

93.24 (d) The commissioner, in consultation with stakeholders, must develop and implement
93.25 a process for providing training and technical assistance necessary to support provider
93.26 submission of cost data required under this subdivision.

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

93.28 Sec. 21. Minnesota Statutes 2024, section 256S.21, subdivision 3, is amended to read:

93.29 Subd. 3. **Cost reporting.** (a) As determined by the commissioner, in consultation with
93.30 stakeholders, a provider enrolled to provide services with rates determined under this chapter
93.31 must submit requested cost data to the commissioner to support evaluation of the rate
93.32 methodologies in this chapter. Requested cost data may include but are not limited to:

93.33 (1) worker wage costs;

- 94.1 (2) benefits paid;
- 94.2 (3) supervisor wage costs;
- 94.3 (4) executive wage costs;
- 94.4 (5) vacation, sick, and training time paid;
- 94.5 (6) taxes, workers' compensation, and unemployment insurance costs paid;
- 94.6 (7) administrative costs paid;
- 94.7 (8) program costs paid;
- 94.8 (9) transportation costs paid;
- 94.9 (10) vacancy rates; and
- 94.10 (11) other data relating to costs required to provide services requested by the
- 94.11 commissioner.

94.12 (b) At least once in any five-year period, a provider must submit the required cost data

94.13 for a fiscal year that ended not more than 18 months prior to the submission date. The

94.14 commissioner ~~shall~~ must provide each provider a 90-day notice prior to the provider's

94.15 submission due date. The commissioner may review report submissions for inaccurate,

94.16 inconclusive, incomplete, or otherwise deficient data and may remove the report from

94.17 submitted status for further verification. If by 30 days after the required submission date a

94.18 provider fails to submit required reporting data, the commissioner ~~shall~~ must provide notice

94.19 to the provider; ~~and~~. If by 60 days after the required submission date a provider has not

94.20 provided the required data, the commissioner ~~shall~~ must provide a second notice. The

94.21 commissioner ~~shall~~ must temporarily suspend payments to ~~the~~ a provider if the commissioner

94.22 has not received the required cost data is not received 90 days after the required submission

94.23 date or 90 days after the department requests updated data. The commissioner must make

94.24 withheld payments must be made once data is received when the required cost data is

94.25 received and reviewed for compliance by the commissioner.

94.26 (c) The commissioner shall coordinate the cost reporting activities required under this

94.27 section with the cost reporting activities directed under section 256B.4914, subdivision 10a.

94.28 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in

94.29 consultation with stakeholders, may submit recommendations on rate methodologies in this

94.30 chapter, including ways to monitor and enforce the spending requirements directed in section

94.31 ~~256S.2101, subdivision 3,~~ 256S.211, subdivision 4, through the reports directed by

94.32 subdivision 2.

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

95.2 Sec. 22. Laws 2024, chapter 125, article 1, section 47, is amended to read:

95.3 Sec. 47. **DIRECTION TO COMMISSIONER; PEDIATRIC HOSPITAL-TO-HOME**
95.4 **TRANSITION PILOT PROGRAM.**

95.5 (a) The commissioner of human services must award a single competitive grant to a
95.6 home care nursing provider to develop and implement, in coordination with the commissioner
95.7 of health, Fairview Masonic Children's Hospital, Gillette Children's Specialty Healthcare,
95.8 and Children's Minnesota of St. Paul and Minneapolis, a pilot program to expedite and
95.9 facilitate pediatric hospital-to-home discharges for patients receiving services in this state
95.10 under medical assistance, including under the community alternative care waiver, community
95.11 access for disability inclusion waiver, and developmental disabilities waiver.

95.12 (b) Grant money awarded under this section must be used only to support the
95.13 administrative, training, and auxiliary services necessary to reduce:

95.14 (1) delayed discharge days due to unavailability of home care nursing staffing to
95.15 accommodate complex pediatric patients;

95.16 (2) avoidable rehospitalization days for pediatric patients;

95.17 (3) unnecessary emergency department utilization by pediatric patients following
95.18 discharge;

95.19 (4) long-term nursing needs for pediatric patients; and

95.20 (5) the number of school days missed by pediatric patients.

95.21 (c) Grant money must not be used to supplant payment rates for services covered under
95.22 Minnesota Statutes, chapter 256B.

95.23 (d) No later than December 15, ~~2026~~ 2027, the commissioner must prepare a report
95.24 summarizing the impact of the pilot program that includes but is not limited to: (1) the
95.25 number of delayed discharge days eliminated; (2) the number of rehospitalization days
95.26 eliminated; (3) the number of unnecessary emergency department admissions eliminated;
95.27 (4) the number of missed school days eliminated; and (5) an estimate of the return on
95.28 investment of the pilot program.

95.29 (e) The commissioner must submit the report under paragraph (d) to the chairs and
95.30 ranking minority members of the legislative committees with jurisdiction over health and
95.31 human services finance and policy.

96.1 Sec. 23. **REPEALER.**

96.2 Minnesota Statutes 2024, section 256B.5012, subdivisions 4, 5, 6, 7, 8, 9, 10, 11, 12,
 96.3 14, 15, and 16, are repealed.

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

96.5 ARTICLE 6

96.6 BEHAVIORAL HEALTH POLICY

96.7 Section 1. Minnesota Statutes 2025 Supplement, section 245.469, subdivision 1, is amended
 96.8 to read:

96.9 Subdivision 1. **Availability of emergency services.** (a) County boards must provide or
 96.10 contract for enough emergency services within the county to meet the needs of adults,
 96.11 children, and families in the county who are experiencing an emotional crisis or mental
 96.12 illness. Clients must not be charged for services provided. Emergency service providers
 96.13 must not delay or deny the timely provision of emergency services to a client due to payor
 96.14 source for services and must meet the qualifications under section 256B.0624, subdivision
 96.15 4. Emergency services must include assessment, crisis intervention, and appropriate case
 96.16 disposition. Emergency services must:

96.17 (1) promote the safety and emotional stability of each client;

96.18 (2) minimize further deterioration of each client;

96.19 (3) help each client to obtain ongoing care and treatment;

96.20 (4) prevent placement in settings that are more intensive, costly, or restrictive than
 96.21 necessary and appropriate to meet client needs; and

96.22 (5) provide support, psychoeducation, and referrals to each client's family members,
 96.23 service providers, and other third parties on behalf of the client in need of emergency
 96.24 services.

96.25 (b) If a county provides engagement services under section 253B.041, the county's
 96.26 emergency service providers must refer clients to engagement services when the client
 96.27 meets the criteria for engagement services.

96.28 Sec. 2. Minnesota Statutes 2024, section 245F.02, subdivision 17, is amended to read:

96.29 Subd. 17. **Peer recovery support services.** "Peer recovery support services" means
 96.30 services provided according to section ~~245F.08, subdivision 3~~ 254B.052.

97.1 Sec. 3. Minnesota Statutes 2025 Supplement, section 245F.08, subdivision 3, is amended
97.2 to read:

97.3 Subd. 3. **Peer recovery support services.** Peer recovery support services must meet the
97.4 requirements in section ~~245G.07, subdivision 2a, paragraph (b), clause (2)~~ 254B.052, and
97.5 must be provided by a person who is qualified according to the requirements in section
97.6 ~~245F.15, subdivision 7~~ 245I.04, subdivisions 18 and 19.

97.7 Sec. 4. Minnesota Statutes 2024, section 245F.15, subdivision 7, is amended to read:

97.8 Subd. 7. **Recovery peer qualifications.** Recovery peers must:

97.9 (1) meet the qualifications in section 245I.04, subdivision 18; and

97.10 (2) provide services according to the scope of practice established in section 245I.04,
97.11 subdivision 19, ~~under the supervision of an alcohol and drug counselor.~~

97.12 Sec. 5. Minnesota Statutes 2024, section 245G.04, is amended by adding a subdivision to
97.13 read:

97.14 Subd. 4. **Tobacco educational material.** A license holder must provide tobacco and
97.15 nicotine educational material to a client on the day of service initiation. The license holder
97.16 must use educational material approved by the commissioner that contains information on:

97.17 (1) risks associated with use of tobacco or nicotine products;

97.18 (2) types of tobacco or nicotine products, including differentiating between commercial
97.19 versus traditional or sacred tobacco;

97.20 (3) treatment options, including the use of medication for tobacco use disorder; and

97.21 (4) benefits of receiving treatment for tobacco or nicotine use while attending substance
97.22 use disorder treatment for another primary substance.

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

97.24 Sec. 6. Minnesota Statutes 2024, section 245G.06, subdivision 4, is amended to read:

97.25 Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a
97.26 service discharge summary for each client. The service discharge summary must be
97.27 completed within five days of the client's service termination, excluding weekends and
97.28 holidays. A copy of the client's service discharge summary must be provided to the client
97.29 upon the client's request.

98.1 (b) The service discharge summary must be recorded in the six dimensions listed in
98.2 section 254B.04, subdivision 4, and include the following information:

98.3 (1) the client's issues, strengths, and needs while participating in treatment, including
98.4 services provided;

98.5 (2) the client's progress toward achieving each goal identified in the individual treatment
98.6 plan;

98.7 (3) a risk rating and description for each of the ASAM six dimensions;

98.8 (4) the reasons for and circumstances of service termination. If a program discharges a
98.9 client at staff request, the reason for discharge and the procedure followed for the decision
98.10 to discharge must be documented and comply with the requirements in section 245G.14,
98.11 subdivision 3, clause (3);

98.12 (5) the client's living arrangements at service termination;

98.13 (6) continuing care recommendations, including transitions between more or less intense
98.14 services, or more frequent to less frequent services, and referrals made with specific attention
98.15 to continuity of care for mental health, as needed; and

98.16 (7) service termination diagnosis.

98.17 Sec. 7. Minnesota Statutes 2025 Supplement, section 245G.09, subdivision 3, is amended
98.18 to read:

98.19 Subd. 3. **Contents.** (a) Client records must contain the following:

98.20 (1) documentation that the client was given:

98.21 (i) information on client rights and responsibilities and grievance procedures on the day
98.22 of service initiation;

98.23 (ii) information on tuberculosis and HIV within 72 hours of service initiation;

98.24 (iii) an orientation to the program abuse prevention plan required under section 245A.65,
98.25 subdivision 2, paragraph (a), clause (4), within 24 hours of admission or, for clients who
98.26 would benefit from a later orientation, 72 hours; and

98.27 (iv) opioid educational material according to section 245G.04, subdivision 3, and tobacco
98.28 educational material according to section 245G.04, subdivision 4, on the day of service
98.29 initiation;

98.30 (2) an initial services plan completed according to section 245G.04;

99.1 (3) a comprehensive assessment completed according to section 245G.05;

99.2 (4) an individual abuse prevention plan according to sections 245A.65, subdivision 2,
99.3 and 626.557, subdivision 14, when applicable;

99.4 (5) an individual treatment plan according to section 245G.06, subdivisions 1 and 1a;

99.5 (6) documentation of treatment services, significant events, appointments, concerns, and
99.6 treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, 3, and 3a; and

99.7 (7) a summary at the time of service termination according to section 245G.06,
99.8 subdivision 4.

99.9 (b) For a client that transfers to another of the license holder's licensed treatment locations,
99.10 the license holder is not required to complete new documents or orientation for the client,
99.11 except that the client must receive an orientation to the new location's grievance procedure,
99.12 program abuse prevention plan, and maltreatment of minor and vulnerable adults reporting
99.13 procedures.

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

99.15 Sec. 8. Minnesota Statutes 2025 Supplement, section 245G.11, subdivision 7, is amended
99.16 to read:

99.17 Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination
99.18 must be provided by qualified staff. An individual is qualified to provide treatment
99.19 coordination if the individual meets the qualifications of an alcohol and drug counselor
99.20 under subdivision 5 or if the individual:

99.21 (1) is skilled in the process of identifying and assessing a wide range of client needs;

99.22 (2) is knowledgeable about local community resources and how to use those resources
99.23 for the benefit of the client;

99.24 (3) has completed 15 hours of education or training on substance use disorder,
99.25 co-occurring conditions, and care coordination for individuals with substance use disorder
99.26 or co-occurring conditions that is consistent with national evidence-based standards;

99.27 (4) meets one of the following criteria:

99.28 ~~(i) has a bachelor's degree in one of the behavioral sciences or related fields;~~

99.29 ~~(ii)~~ (i) has a high school diploma or equivalent; or

99.30 ~~(iii)~~ (ii) is a mental health practitioner who meets the qualifications under section 245I.04,
99.31 subdivision 4; and

100.1 (5) either has at least 1,000 hours of supervised experience working with individuals
100.2 with substance use disorder or co-occurring conditions or receives treatment supervision at
100.3 least once per week until obtaining 1,000 hours of supervised experience working with
100.4 individuals with substance use disorder or co-occurring conditions.

100.5 (b) A treatment coordinator must receive the following levels of supervision from an
100.6 alcohol and drug counselor or a mental health professional whose scope of practice includes
100.7 substance use disorder treatment and assessments:

100.8 (1) for a treatment coordinator that has not obtained 1,000 hours of supervised experience
100.9 under paragraph (a), clause (5), at least one hour of supervision per week; or

100.10 (2) for a treatment coordinator that has obtained at least 1,000 hours of supervised
100.11 experience under paragraph (a), clause (5), at least one hour of supervision per month.

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

100.13 Sec. 9. Minnesota Statutes 2024, section 245G.11, subdivision 8, is amended to read:

100.14 Subd. 8. **Recovery peer qualifications.** A recovery peer must:

100.15 (1) meet the qualifications in section 245I.04, subdivision 18; and

100.16 (2) provide services according to the scope of practice established in section 245I.04,
100.17 subdivision 19, ~~under the supervision of an alcohol and drug counselor.~~

100.18 Sec. 10. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended
100.19 to read:

100.20 Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment
100.21 supervision of a mental health professional, a mental health behavioral aide may practice
100.22 psychosocial skills with a child client according to the child's treatment plan ~~and individual~~
100.23 ~~behavior plan~~ that a mental health professional, clinical trainee, or behavioral health
100.24 practitioner has previously taught to the child.

100.25 Sec. 11. Minnesota Statutes 2024, section 245I.04, is amended by adding a subdivision
100.26 to read:

100.27 **Subd. 20. Limitation on affiliation across service lines.** (a) A mental health professional,
100.28 as defined in subdivision 3, must not simultaneously serve in a clinical, supervisory, or
100.29 designated role for more than ten distinct licensed provider organizations or service lines
100.30 delivering Medicaid-funded services. A mental health professional must not provide clinical
100.31 or administrative supervision to more than 20 direct care or clinical staff across all affiliated

101.1 provider organizations and service lines unless an exception is granted by the commissioner
101.2 under paragraph (c).

101.3 (b) The commissioner shall establish criteria and a standardized process for evaluating
101.4 exception requests under paragraph (a).

101.5 (c) Upon written request, the commissioner may grant an exception if the requester
101.6 demonstrates that:

101.7 (1) the mental health professional can effectively meet all clinical, supervisory, and
101.8 administrative responsibilities across affiliated programs;

101.9 (2) the oversight of client care will not be compromised; and

101.10 (3) the proposed arrangement complies with all applicable supervision, documentation,
101.11 and service delivery requirements.

101.12 (d) In determining whether to grant an exception under paragraph (c), the commissioner
101.13 shall consider:

101.14 (1) the geographic distribution of services;

101.15 (2) the complexity and acuity of client needs;

101.16 (3) the mental health professional's other responsibilities, including but not limited to
101.17 direct service provision; and

101.18 (4) whether adequate supervision can be maintained in compliance with program
101.19 standards.

101.20 (e) The commissioner shall rescind approval of the exception granted under paragraph
101.21 (c) if the requester fails to comply with applicable program standards or with the terms of
101.22 the exception.

101.23 (f) A mental health professional determined to be in violation of this subdivision may
101.24 be subject to corrective action, licensing sanctions, or administrative penalties in accordance
101.25 with chapter 245A and other applicable law.

101.26 Sec. 12. Minnesota Statutes 2024, section 245I.08, subdivision 4, is amended to read:

101.27 Subd. 4. **Progress notes.** A license holder must use a progress note to document each
101.28 occurrence of a mental health service that a staff person provides to a client. A progress
101.29 note must include the following:

101.30 (1) the type of service;

- 102.1 (2) the date of service;
- 102.2 (3) the start and stop time of the service unless the license holder is licensed as a
102.3 residential program;
- 102.4 (4) the location of the service;
- 102.5 (5) the scope of the service, including: (i) the targeted goal and objective; (ii) the
102.6 intervention that the staff person provided to the client and the methods that the staff person
102.7 used; (iii) the client's response to the intervention; and (iv) the staff person's plan to take
102.8 future actions, including changes in treatment that the staff person will implement if the
102.9 intervention was ineffective;
- 102.10 (6) the signature and credentials of the staff person who provided the service to the
102.11 client;
- 102.12 (7) the dated signature and credentials of the treatment supervisor;
- 102.13 ~~(7)~~ (8) the mental health provider travel documentation required by section 256B.0625,
102.14 if applicable; and
- 102.15 ~~(8)~~ (9) significant observations by the staff person, if applicable, including: (i) the client's
102.16 current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with
102.17 or referrals to other professionals, family, or significant others; and (iv) changes in the
102.18 client's mental or physical symptoms.

102.19 Sec. 13. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

102.20 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health
102.21 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
102.22 A standard diagnostic assessment of a client must include a face-to-face interview with a
102.23 client and a written evaluation of the client. The assessor must complete a client's standard
102.24 diagnostic assessment within the client's cultural context. An alcohol and drug counselor
102.25 may gather and document the information in paragraphs (b) and (c) when completing a
102.26 comprehensive assessment according to section 245G.05.

102.27 (b) When completing a standard diagnostic assessment of a client, the assessor must
102.28 gather and document information about the client's current life situation, including the
102.29 following information:

- 102.30 (1) the client's age;
- 102.31 (2) the client's current living situation, including the client's housing status and household
102.32 members;

- 103.1 (3) the status of the client's basic needs;
- 103.2 (4) the client's education level and employment status;
- 103.3 (5) the client's current medications;
- 103.4 (6) any immediate risks to the client's health and safety, including withdrawal symptoms,
- 103.5 medical conditions, and behavioral and emotional symptoms;
- 103.6 (7) the client's perceptions of the client's condition;
- 103.7 (8) the client's description of the client's symptoms, including the reason for the client's
- 103.8 referral;
- 103.9 (9) the client's history of mental health and substance use disorder treatment, including
- 103.10 but not limited to treatment for tobacco or nicotine use;
- 103.11 (10) cultural influences on the client; and
- 103.12 (11) substance use history, if applicable, including:
- 103.13 (i) amounts and types of substances, including but not limited to tobacco and nicotine
- 103.14 products; frequency and duration; route of administration; periods of abstinence; and
- 103.15 circumstances of relapse; and
- 103.16 (ii) the impact to functioning when under the influence of substances, including legal
- 103.17 interventions.
- 103.18 (c) If the assessor cannot obtain the information that this paragraph requires without
- 103.19 retraumatizing the client or harming the client's willingness to engage in treatment, the
- 103.20 assessor must identify which topics will require further assessment during the course of the
- 103.21 client's treatment. The assessor must gather and document information related to the following
- 103.22 topics:
- 103.23 (1) the client's relationship with the client's family and other significant personal
- 103.24 relationships, including the client's evaluation of the quality of each relationship;
- 103.25 (2) the client's strengths and resources, including the extent and quality of the client's
- 103.26 social networks;
- 103.27 (3) important developmental incidents in the client's life;
- 103.28 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;
- 103.29 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

104.1 (6) the client's health history and the client's family health history, including the client's
104.2 physical, chemical, and mental health history.

104.3 (d) When completing a standard diagnostic assessment of a client, an assessor must use
104.4 a recognized diagnostic framework.

104.5 (1) When completing a standard diagnostic assessment of a client who is five years of
104.6 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic
104.7 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
104.8 published by Zero to Three.

104.9 (2) When completing a standard diagnostic assessment of a client who is six years of
104.10 age or older, the assessor must use the current edition of the Diagnostic and Statistical
104.11 Manual of Mental Disorders published by the American Psychiatric Association.

104.12 (3) When completing a standard diagnostic assessment of a client who is 18 years of
104.13 age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria
104.14 in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders
104.15 published by the American Psychiatric Association to screen and assess the client for a
104.16 substance use disorder, including but not limited to tobacco use disorder.

104.17 (e) When completing a standard diagnostic assessment of a client, the assessor must
104.18 include and document the following components of the assessment:

104.19 (1) the client's mental status examination;

104.20 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
104.21 vulnerabilities; safety needs, including client information that supports the assessor's findings
104.22 after applying a recognized diagnostic framework from paragraph (d); and any differential
104.23 diagnosis of the client; and

104.24 (3) an explanation of: (i) how the assessor diagnosed the client using the information
104.25 from the client's interview, assessment, psychological testing, and collateral information
104.26 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
104.27 and (v) the client's responsivity factors.

104.28 (f) When completing a standard diagnostic assessment of a client, the assessor must
104.29 consult the client and the client's family about which services that the client and the family
104.30 prefer to treat the client. The assessor must make referrals for the client as to services required
104.31 by law.

105.1 (g) Information from other providers and prior assessments may be used to complete
105.2 the diagnostic assessment if the source of the information is documented in the diagnostic
105.3 assessment.

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

105.5 Sec. 14. Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 7, is amended
105.6 to read:

105.7 Subd. 7. **Intensive residential treatment services assessment and treatment**
105.8 **planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and
105.9 document the client's immediate needs, including the client's:

105.10 (1) health and safety, including the client's need for crisis assistance;

105.11 (2) responsibilities for children, family and other natural supports, and employers; and

105.12 (3) housing and legal issues.

105.13 (b) Within 24 hours of the client's admission, the license holder must complete an initial
105.14 treatment plan for the client. The license holder must:

105.15 (1) base the client's initial treatment plan on the client's referral information and an
105.16 assessment of the client's immediate needs;

105.17 (2) consider crisis assistance strategies that have been effective for the client in the past;

105.18 (3) identify the client's initial treatment goals, measurable treatment objectives, and
105.19 specific interventions that the license holder will use to help the client engage in treatment;

105.20 (4) identify the participants involved in the client's treatment planning. The client must
105.21 be a participant; and

105.22 (5) ensure that a treatment supervisor approves of the client's initial treatment plan if a
105.23 behavioral health practitioner or clinical trainee completes the client's treatment plan,
105.24 notwithstanding section 245I.08, subdivision 3.

105.25 (c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must
105.26 complete an individual abuse prevention plan as part of a client's initial treatment plan.

105.27 (d) Within five days of the client's admission and again within 60 days after the client's
105.28 admission, the license holder must complete a level of care assessment of the client. If the
105.29 license holder determines that a client does not need a medically monitored level of service,
105.30 a treatment supervisor must document how the client's admission to and continued services
105.31 in intensive residential treatment services are medically necessary for the client.

106.1 (e) Within ten days of a client's admission, excluding weekends and holidays, the license
106.2 holder must complete or review and update the client's standard diagnostic assessment.

106.3 (f) Within ten days of a client's admission, the license holder must complete the client's
106.4 individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days
106.5 after the client's admission and again within 70 days after the client's admission, the license
106.6 holder must update the client's individual treatment plan. The license holder must focus the
106.7 client's treatment planning on preparing the client for a successful transition from intensive
106.8 residential treatment services to another setting. In addition to the required elements of an
106.9 individual treatment plan under section 245I.10, subdivision 8, the license holder must
106.10 identify the following information in the client's individual treatment plan: (1) the client's
106.11 referrals and resources for the client's health and safety; and (2) the staff persons who are
106.12 responsible for following up with the client's referrals and resources. If the client does not
106.13 receive a referral or resource that the client needs, the license holder must document the
106.14 reason that the license holder did not make the referral or did not connect the client to a
106.15 particular resource. The license holder is responsible for determining whether additional
106.16 follow-up is required on behalf of the client.

106.17 (g) Within 30 days of the client's admission, the license holder must complete a functional
106.18 assessment of the client. Within 60 days after the client's admission, the license holder must
106.19 update the client's functional assessment to include any changes in the client's functioning
106.20 and symptoms.

106.21 (h) For a client with a current substance use disorder diagnosis and for a client whose
106.22 substance use disorder screening in the client's standard diagnostic assessment indicates the
106.23 possibility that the client has a substance use disorder, the license holder must complete a
106.24 written assessment of the client's substance use within 30 days of the client's admission. In
106.25 the substance use assessment, the license holder must: (1) evaluate the client's history of
106.26 substance use, relapses, and hospitalizations related to substance use; (2) assess the effects
106.27 of the client's substance use on the client's relationships including with family member and
106.28 others; (3) identify financial problems, health issues, housing instability, and unemployment;
106.29 (4) assess the client's legal problems, past and pending incarceration, violence, and
106.30 victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking
106.31 prescribed medications, and noncompliance with psychosocial treatment.

106.32 (i) On a weekly basis, a mental health professional or certified rehabilitation specialist
106.33 must review each client's treatment plan and individual abuse prevention plan. The license
106.34 holder must document in the client's file each weekly review of the client's treatment plan
106.35 and individual abuse prevention plan.

107.1 Sec. 15. Minnesota Statutes 2025 Supplement, section 254A.03, subdivision 3, is amended
107.2 to read:

107.3 Subd. 3. **Rules for substance use disorder care.** (a) An eligible vendor of comprehensive
107.4 assessments under section 254B.0501 may determine the appropriate level of substance use
107.5 disorder treatment for a recipient of public assistance. The process for determining an
107.6 individual's financial eligibility for the behavioral health fund or determining an individual's
107.7 enrollment in or eligibility for a publicly subsidized health plan is not affected by the
107.8 individual's choice to access a comprehensive assessment for placement.

107.9 ~~(b) The commissioner shall develop and implement a utilization review process for~~
107.10 ~~publicly funded treatment placements to monitor and review the clinical appropriateness~~
107.11 ~~and timeliness of all publicly funded placements in treatment.~~

107.12 ~~(e)~~ (b) If a screen result is positive for alcohol or substance misuse, a brief screening for
107.13 alcohol or substance use disorder that is provided to a recipient of public assistance within
107.14 a primary care clinic, hospital, or other medical setting or school setting establishes medical
107.15 necessity and approval for an initial set of substance use disorder services identified in
107.16 section 254B.0505. The initial set of services approved for a recipient whose screen result
107.17 is positive may include any combination of up to four hours of individual or group substance
107.18 use disorder treatment, two hours of substance use disorder treatment coordination, or two
107.19 hours of substance use disorder peer support services provided by a qualified individual
107.20 according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph
107.21 (a) to be approved for additional treatment services. A comprehensive assessment pursuant
107.22 to section 245G.05 is not required to receive the initial set of services allowed under this
107.23 subdivision. A positive screen result establishes eligibility for the initial set of services
107.24 allowed under this subdivision.

107.25 ~~(d)~~ (c) An individual may choose to obtain a comprehensive assessment as provided in
107.26 section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled
107.27 provider that is licensed to provide the level of service authorized pursuant to section
107.28 254A.19, subdivision 3. If the individual is enrolled in a prepaid health plan, the individual
107.29 must comply with any provider network requirements or limitations.

107.30 Sec. 16. Minnesota Statutes 2025 Supplement, section 254B.04, subdivision 1a, is amended
107.31 to read:

107.32 Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal
107.33 Regulations, title 25, part 20, who meet the income standards of section 256B.056,
107.34 subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health

108.1 fund services. State money appropriated for this paragraph must be placed in a separate
108.2 account established for this purpose.

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

108.11 (c) Notwithstanding paragraph (a), any person enrolled in medical assistance or
108.12 MinnesotaCare is eligible for room and board services under section 254B.0505, subdivision
108.13 1, clause (9).

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

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

108.17 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
108.18 9505.0010 to 9505.0140;

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

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

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

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

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

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

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

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

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

109.9 (h) When a county commits a client under chapter 253B to a regional treatment center
109.10 for substance use disorder services and the client is ineligible for the behavioral health fund,
109.11 the county is responsible for the payment to the regional treatment center according to
109.12 section 254B.0501, subdivision 3.

109.13 (i) Notwithstanding any law to the contrary, persons enrolled in MinnesotaCare or
109.14 medical assistance are eligible for room and board services when provided through intensive
109.15 residential treatment services and residential crisis services under section 256B.0632 and
109.16 chapter 245I.

109.17 (j) A person is eligible for one 60-consecutive-calendar-day period per year. A person
109.18 may submit a request for additional eligibility to the commissioner. A person denied
109.19 additional eligibility under this paragraph may request a state agency hearing under section
109.20 256.045.

109.21 Sec. 17. Minnesota Statutes 2025 Supplement, section 254B.0501, subdivision 6, is
109.22 amended to read:

109.23 Subd. 6. **Recovery community organizations.** (a) A recovery community organization
109.24 that meets the requirements of clauses (1) to (15), complies with the training requirements
109.25 in section 254B.052, subdivision 4, and meets certification requirements of the Minnesota
109.26 Alliance of Recovery Community Organizations or another Minnesota statewide recovery
109.27 organization identified by the commissioner is an eligible vendor of peer recovery support
109.28 services. If the commissioner does not identify another statewide recovery organization, or
109.29 the Minnesota Alliance of Recovery Community Organizations or the statewide recovery
109.30 organization identified by the commissioner is not reasonably positioned to certify vendors,
109.31 the commissioner must determine the eligibility of a vendor of peer recovery support services.
109.32 A Minnesota statewide recovery organization identified by the commissioner must update
109.33 recovery community organization applicants for certification on the status of the application

110.1 within 45 days of receipt. If the approved statewide recovery organization denies an
110.2 application, it must provide a written explanation for the denial to the recovery community
110.3 organization. Eligible vendors under this paragraph must:

110.4 (1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be
110.5 free from conflicting self-interests, and be autonomous in decision-making, program
110.6 development, peer recovery support services provided, and advocacy efforts for the purpose
110.7 of supporting the recovery community organization's mission;

110.8 (2) be led and governed by individuals in the recovery community, with more than 50
110.9 percent of the board of directors or advisory board members self-identifying as people in
110.10 personal recovery from substance use disorders;

110.11 (3) have a mission statement and conduct corresponding activities indicating that the
110.12 organization's primary purpose is to support recovery from substance use disorder;

110.13 (4) demonstrate ongoing community engagement with the identified primary region and
110.14 population served by the organization, including individuals in recovery and their families,
110.15 friends, and recovery allies;

110.16 (5) be accountable to the recovery community through documented priority-setting and
110.17 participatory decision-making processes that promote the engagement of, and consultation
110.18 with, people in recovery and their families, friends, and recovery allies;

110.19 (6) provide nonclinical peer recovery support services, including but not limited to
110.20 recovery support groups, recovery coaching, telephone recovery support, skill-building,
110.21 and harm-reduction activities, and provide recovery public education and advocacy;

110.22 (7) have written policies that allow for and support opportunities for all paths toward
110.23 recovery and refrain from excluding anyone based on their chosen recovery path, which
110.24 may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based
110.25 paths;

110.26 (8) maintain organizational practices to meet the needs of Black, Indigenous, and people
110.27 of color communities, LGBTQ+ communities, and other underrepresented or marginalized
110.28 communities. Organizational practices may include board and staff training, service offerings,
110.29 advocacy efforts, and culturally informed outreach and services;

110.30 (9) use recovery-friendly language in all media and written materials that is supportive
110.31 of and promotes recovery across diverse geographical and cultural contexts and reduces
110.32 stigma;

111.1 (10) establish and maintain a publicly available recovery community organization code
111.2 of ethics and grievance policy and procedures;

111.3 (11) not classify or treat any recovery peer hired on or after July 1, 2024, as an
111.4 independent contractor;

111.5 (12) not classify or treat any recovery peer as an independent contractor on or after
111.6 January 1, 2025;

111.7 (13) provide an orientation for recovery peers that includes an overview of the consumer
111.8 advocacy services provided by the Ombudsman for Mental Health and Developmental
111.9 Disabilities and other relevant advocacy services;

111.10 (14) provide notice to peer recovery support services participants that includes the
111.11 following statement: "If you have a complaint about the provider or the person providing
111.12 your peer recovery support services, you may contact the Minnesota Alliance of Recovery
111.13 Community Organizations. You may also contact the Office of Ombudsman for Mental
111.14 Health and Developmental Disabilities." The statement must also include:

111.15 (i) the telephone number, website address, email address, and mailing address of the
111.16 Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman
111.17 for Mental Health and Developmental Disabilities;

111.18 (ii) the recovery community organization's name, address, email, telephone number, and
111.19 name or title of the person at the recovery community organization to whom problems or
111.20 complaints may be directed; and

111.21 (iii) a statement that the recovery community organization will not retaliate against a
111.22 peer recovery support services participant because of a complaint; and

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

111.24 (b) A recovery community organization approved by the commissioner before June 30,
111.25 2023, must have begun the application process as required by an approved certifying or
111.26 accrediting entity and have begun the process to meet the requirements under paragraph (a)
111.27 by September 1, 2024, in order to be considered as an eligible vendor of peer recovery
111.28 support services.

111.29 (c) A recovery community organization that is aggrieved by a certification determination
111.30 and believes it meets the requirements under paragraph (a) may appeal the determination
111.31 under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an
111.32 eligible vendor. If the human services judge determines that the recovery community
111.33 organization meets the requirements under paragraph (a), the recovery community

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

112.5 (d) All recovery community organizations must be certified by an entity listed in
112.6 paragraph (a) by June 30, ~~2027~~ 2026.

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

112.8 Sec. 18. Minnesota Statutes 2025 Supplement, section 254B.0505, subdivision 8, is
112.9 amended to read:

112.10 Subd. 8. ~~Peer recovery support services~~ **Utilization review requirements.** Eligible
112.11 vendors of ~~peer recovery support services~~ in subdivision 1, clauses (1) to (10), must:

112.12 ~~(1) submit to a review by the commissioner of up to ten percent of all medical assistance~~
112.13 ~~and behavioral health fund claims to determine the medical necessity of peer recovery~~
112.14 ~~support services for entities billing for peer recovery support services individually and not~~
112.15 ~~receiving a daily rate; and.~~

112.16 ~~(2) limit an individual client to 14 hours per week for peer recovery support services~~
112.17 ~~from an individual provider of peer recovery support services.~~

112.18 Sec. 19. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding
112.19 a subdivision to read:

112.20 Subd. 9. **Withdrawal management services.** For withdrawal management services
112.21 provided by an eligible vendor that is licensed under chapter 245F as a clinically managed
112.22 withdrawal management program or as a medically monitored withdrawal management
112.23 program, utilization review, as defined in section 62M.02, is prohibited until five calendar
112.24 days after the date of service initiation.

112.25 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
112.26 whichever is later.

112.27 Sec. 20. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding
112.28 a subdivision to read:

112.29 Subd. 10. **Monetary recovery.** Reimbursement for services authorized under this chapter
112.30 that are not provided in accordance with this chapter are subject to monetary recovery under
112.31 section 256B.064 as money improperly paid.

113.1 Sec. 21. Minnesota Statutes 2024, section 254B.052, subdivision 1, is amended to read:

113.2 Subdivision 1. **Peer recovery support services; service requirements.** (a) Peer recovery
113.3 support services are face-to-face interactions between a recovery peer and a client, on a
113.4 one-on-one basis, in which specific goals identified in an individual recovery plan, treatment
113.5 plan, or stabilization plan are discussed and addressed. Peer recovery support services are
113.6 provided to promote a client's recovery goals, self-sufficiency, self-advocacy, and
113.7 development of natural supports and to support maintenance of a client's recovery.

113.8 (b) Peer recovery support services must be provided according to (1) an individual
113.9 recovery plan if provided by a recovery community organization or county, (2) a treatment
113.10 plan if provided in either a substance use disorder treatment program under chapter 245G,
113.11 or a Tribally licensed substance use disorder treatment program, or (3) a stabilization plan
113.12 if provided by a withdrawal management program under chapter 245F.

113.13 (c) A client receiving peer recovery support services must participate in the services
113.14 voluntarily. Any program that incorporates peer recovery support services must provide
113.15 written notice to the client that peer recovery support services will be provided.

113.16 (d) Peer recovery support services may not be provided to a client residing with or
113.17 employed by a recovery peer from whom ~~they receive~~ the client receives services.

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

113.19 Sec. 22. Minnesota Statutes 2024, section 254B.052, is amended by adding a subdivision
113.20 to read:

113.21 **Subd. 7. Billing limits.** Eligible vendors of peer recovery support services must limit
113.22 an individual client to 14 hours per week for peer recovery support services from an
113.23 individual provider of peer recovery support services.

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

113.25 Sec. 23. Minnesota Statutes 2024, section 256B.0624, subdivision 6b, is amended to read:

113.26 Subd. 6b. **Crisis intervention services.** (a) If the crisis assessment determines mobile
113.27 crisis intervention services are needed, the crisis intervention services must be provided
113.28 promptly. As opportunity presents during the intervention, at least two members of the
113.29 mobile crisis intervention team must confer directly or by telephone about the crisis
113.30 assessment, crisis treatment plan, and actions taken and needed. At least one of the team
113.31 members must be providing face-to-face crisis intervention services. If providing crisis

114.1 intervention services, a clinical trainee or mental health practitioner must seek treatment
114.2 supervision as required in subdivision 9.

114.3 (b) If a provider delivers crisis intervention services while the recipient is absent, the
114.4 provider must document the reason for delivering services while the recipient is absent.

114.5 (c) The mobile crisis intervention team must develop a crisis treatment plan according
114.6 to subdivision 11.

114.7 (d) The mobile crisis intervention team must document which crisis treatment plan goals
114.8 and objectives have been met and when no further crisis intervention services are required.

114.9 (e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral
114.10 to other services, the team must provide referrals to these services. If the recipient has a
114.11 case manager, planning for other services must be coordinated with the case manager. If
114.12 the recipient is unable to follow up on the referral, the team must link the recipient to the
114.13 service and follow up to ensure the recipient is receiving the service.

114.14 ~~(f) If the recipient's mental health crisis is stabilized and the recipient does not have an~~
114.15 ~~advance directive, the case manager or crisis team shall offer to work with the recipient to~~
114.16 ~~develop one.~~

114.17 **EFFECTIVE DATE.** This section is effective upon federal approval.

114.18 Sec. 24. Minnesota Statutes 2024, section 256B.0624, subdivision 7, is amended to read:

114.19 Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided
114.20 by qualified staff of a crisis stabilization services provider entity and must meet the following
114.21 standards:

114.22 (1) a crisis treatment plan must be developed that meets the criteria in subdivision 11;

114.23 (2) staff must be qualified as defined in subdivision 8;

114.24 (3) crisis stabilization services must be delivered according to the crisis treatment plan
114.25 and include face-to-face contact with the recipient by qualified staff for further assessment,
114.26 help with referrals, updating of the crisis treatment plan, skills training, and collaboration
114.27 with other service providers in the community; ~~and~~

114.28 (4) if a provider delivers crisis stabilization services while the recipient is absent, the
114.29 provider must document the reason for delivering services while the recipient is absent; and
114.30 and

115.1 (5) if the recipient is an adult, the recipient's mental health crisis is stabilized, and the
115.2 recipient does not have a health care directive as defined by section 145C.01, subdivision
115.3 5a, or psychiatric declaration as defined by section 253B.03, subdivision 6d, the case manager
115.4 or crisis team must offer to work with the recipient to develop a directive or declaration.

115.5 (b) If crisis stabilization services are provided in a supervised, licensed residential setting
115.6 that serves no more than four adult residents, and one or more individuals are present at the
115.7 setting to receive residential crisis stabilization, the residential staff must include, for at
115.8 least eight hours per day, at least one mental health professional, clinical trainee, certified
115.9 rehabilitation specialist, or mental health practitioner. The commissioner shall establish a
115.10 statewide per diem rate for crisis stabilization services provided under this paragraph to
115.11 medical assistance enrollees. The rate for a provider shall not exceed the rate charged by
115.12 that provider for the same service to other payers. Payment shall not be made to more than
115.13 one entity for each individual for services provided under this paragraph on a given day.
115.14 The commissioner shall set rates prospectively for the annual rate period. The commissioner
115.15 shall require providers to submit annual cost reports on a uniform cost reporting form and
115.16 shall use submitted cost reports to inform the rate-setting process. The commissioner shall
115.17 recalculate the statewide per diem every year.

115.18 **EFFECTIVE DATE.** This section is effective upon federal approval.

115.19 Sec. 25. Minnesota Statutes 2024, section 256B.0625, subdivision 47, is amended to read:

115.20 Subd. 47. ~~Treatment foster care~~ **Children's intensive behavioral health**
115.21 **services.** ~~Effective July 1, 2011, and subject to federal approval,~~ Medical assistance covers
115.22 ~~treatment foster care~~ children's intensive behavioral health services according to section
115.23 256B.0946.

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

115.25 Sec. 26. Minnesota Statutes 2024, section 256B.0759, subdivision 3, is amended to read:

115.26 Subd. 3. **Provider standards.** (a) ~~The commissioner must establish requirements for~~
115.27 ~~participating providers that are consistent with the federal requirements of the demonstration~~
115.28 ~~project.~~ The following programs that receive payment for substance use disorder treatment
115.29 services under section 256B.0625 must enroll as a Minnesota health care programs provider,
115.30 meet the requirements established by the commissioner, and certify that the program meets
115.31 the applicable American Society of Addiction Medicine (ASAM) levels of care according
115.32 to section 254B.19:

116.1 (1) nonresidential substance use disorder treatment programs and residential treatment
116.2 programs licensed under chapter 245G as licensed substance use disorder treatment facilities;

116.3 (2) withdrawal management programs licensed under chapter 245F; and

116.4 (3) out-of-state residential substance use disorder treatment programs.

116.5 (b) Programs that do not meet the requirements of paragraph (a) are ineligible for payment
116.6 for services provided under section 256B.0625.

116.7 ~~(b) A participating residential provider must obtain applicable licensure under chapter~~
116.8 ~~245F or 245G or other applicable standards for the services provided and must:~~

116.9 ~~(1) deliver services in accordance with standards published by the commissioner pursuant~~
116.10 ~~to paragraph (d);~~

116.11 ~~(2) maintain formal patient referral arrangements with providers delivering step-up or~~
116.12 ~~step-down levels of care in accordance with ASAM standards; and~~

116.13 ~~(3) offer substance use disorder treatment services with medications for opioid use~~
116.14 ~~disorder on site or facilitate access to substance use disorder treatment services with~~
116.15 ~~medications for opioid use disorder off site.~~

116.16 ~~(c) A participating outpatient provider must obtain applicable licensure under chapter~~
116.17 ~~245G or other applicable standards for the services provided and must:~~

116.18 ~~(1) deliver services in accordance with standards published by the commissioner pursuant~~
116.19 ~~to paragraph (d); and~~

116.20 ~~(2) maintain formal patient referral arrangements with providers delivering step-up or~~
116.21 ~~step-down levels of care in accordance with ASAM standards.~~

116.22 ~~(d) If the provider standards under chapter 245G or other applicable standards conflict~~
116.23 ~~or are duplicative, the commissioner may grant variances to the standards if the variances~~
116.24 ~~do not conflict with federal requirements. The commissioner must publish service~~
116.25 ~~components, service standards, and staffing requirements for participating providers that~~
116.26 ~~are consistent with ASAM standards and federal requirements by October 1, 2020.~~

116.27 (c) Programs licensed by the department as residential treatment programs according to
116.28 section 245G.21 that (1) receive payment under this chapter, (2) are licensed as a hospital
116.29 under sections 144.50 to 144.581, and (3) provide only ASAM level 3.7 medically monitored
116.30 inpatient level of care are not required to certify the ASAM 3.7 level of care. If a program
116.31 described in this paragraph provides any additional ASAM levels of care, the program must
116.32 certify those levels of care according to section 254B.19. Programs meeting the criteria in

117.1 this paragraph must submit evidence of providing the required level of care to the
117.2 commissioner to be exempt from enrolling in the demonstration.

117.3 (d) Tribally licensed programs that otherwise meet the requirements of subdivision 3
117.4 may elect to participate in the demonstration project. The department must consult with
117.5 Tribal Nations to discuss participation in the substance use disorder demonstration project.

117.6 (e) Programs subject to this section must:

117.7 (1) deliver services in accordance with section 254B.19; and

117.8 (2) offer substance use disorder treatment services with medications for opioid use
117.9 disorder on site or facilitate timely access to medications for opioid use disorder off site.

117.10 Sec. 27. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is
117.11 amended to read:

117.12 **Subd. 4. Provider payment rates.** ~~(a) Payment rates for participating Providers must~~
117.13 ~~be increased for services provided to medical assistance enrollees. To receive a rate increase,~~
117.14 ~~participating providers must meet demonstration project requirements and provide evidence~~
117.15 ~~of formal referral arrangements with providers delivering step-up or step-down levels of~~
117.16 ~~care. Providers that have enrolled in the demonstration project but have not met the provider~~
117.17 ~~standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under~~
117.18 ~~this subdivision until the date that the provider meets the provider standards in subdivision~~
117.19 ~~3. Services provided from July 1, 2022, to the date that the provider meets the provider~~
117.20 ~~standards under subdivision 3 shall be reimbursed at rates according to section 254B.0505,~~
117.21 ~~subdivision 1. Rate increases paid under this subdivision to a provider for services provided~~
117.22 ~~between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider~~
117.23 ~~is taking meaningful steps to meet demonstration project requirements that are not otherwise~~
117.24 ~~required by law, and the provider provides documentation to the commissioner, upon request,~~
117.25 ~~of the steps being taken.~~

117.26 ~~(b) The commissioner may temporarily suspend payments to the provider according to~~
117.27 ~~section 256B.04, subdivision 21, paragraph (d), if the provider does not meet the requirements~~
117.28 ~~in paragraph (a). Payments withheld from the provider must be made once the commissioner~~
117.29 ~~determines that the requirements in paragraph (a) are met.~~

117.30 ~~(c) For outpatient individual and group substance use disorder services under section~~
117.31 ~~254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed~~
117.32 ~~as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on~~

118.1 ~~or after January 1, 2021, payment rates must be increased by 20 percent over the rates in~~
118.2 ~~effect on December 31, 2020.~~

118.3 ~~(d)~~ (b) Effective January 1, 2021, and contingent on annual federal approval, managed
118.4 care plans and county-based purchasing plans must reimburse providers of the substance
118.5 use disorder services meeting the ~~criteria described in paragraph (a) who~~ requirements of
118.6 section 254B.19 that are employed by or under contract with the plan an amount that is at
118.7 least equal to the fee-for-service base rate payment for the substance use disorder services
118.8 described in paragraph ~~(e)~~ (a). The commissioner must monitor the effect of this requirement
118.9 on the rate of access to substance use disorder services and residential substance use disorder
118.10 rates. Capitation rates paid to managed care organizations and county-based purchasing
118.11 plans must reflect the impact of this requirement. This paragraph expires if federal approval
118.12 is not received at any time as required under this paragraph.

118.13 ~~(e)~~ (c) Effective July 1, 2021, contracts between managed care plans and county-based
118.14 purchasing plans and providers to whom paragraph ~~(d)~~ (b) applies must allow recovery of
118.15 payments from those providers if, for any contract year, federal approval for the provisions
118.16 of paragraph ~~(d)~~ (b) is not received, and capitation rates are adjusted as a result. Payment
118.17 recoveries must not exceed the amount equal to any decrease in rates that results from this
118.18 provision.

118.19 ~~(f)~~ (d) For substance use disorder services with medications for opioid use disorder under
118.20 section 254B.0505, subdivision 1, clause (7), provided on or after January 1, 2021, payment
118.21 rates must be increased by 20 percent over the rates in effect on December 31, 2020. Upon
118.22 implementation of new rates according to section 254B.121, the 20 percent increase will
118.23 no longer apply.

118.24 Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 1, is
118.25 amended to read:

118.26 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
118.27 the meanings given ~~them~~.

118.28 (b) "Children's therapeutic services and supports" means the flexible package of mental
118.29 health services for children who require varying therapeutic and rehabilitative levels of
118.30 intervention to treat a diagnosed mental illness, as defined in section 245.462, subdivision
118.31 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered
118.32 using various treatment modalities and combinations of services designed to reach treatment
118.33 outcomes identified in the individual treatment plan.

119.1 (c) "Clinical trainee" means a staff person who is qualified according to section 245I.04,
119.2 subdivision 6.

119.3 (d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

119.4 (e) "Culturally competent provider" means a provider who understands and can utilize
119.5 to a client's benefit the client's culture when providing services to the client. A provider
119.6 may be culturally competent because the provider is of the same cultural or ethnic group
119.7 as the client or the provider has developed the knowledge and skills through training and
119.8 experience to provide services to culturally diverse clients.

119.9 (f) "Day treatment program" for children means a site-based structured mental health
119.10 program consisting of psychotherapy for three or more individuals and individual or group
119.11 skills training provided by a team, under the treatment supervision of a mental health
119.12 professional.

119.13 (g) "Direct service time" means the time that a mental health professional, clinical trainee,
119.14 mental health practitioner, or mental health behavioral aide spends face-to-face with a client
119.15 and the client's family or providing covered services through telehealth as defined under
119.16 section 256B.0625, subdivision 3b. Direct service time includes time in which the provider
119.17 obtains a client's history, develops a client's treatment plan, records individual treatment
119.18 outcomes, or provides service components of children's therapeutic services and supports.
119.19 Direct service time does not include time doing work before and after providing direct
119.20 services, including scheduling or maintaining clinical records.

119.21 (h) "Direction of mental health behavioral aide" means the activities of a mental health
119.22 professional, clinical trainee, or mental health practitioner in guiding the mental health
119.23 behavioral aide in providing services to a client. The direction of a mental health behavioral
119.24 aide must be based on the client's individual treatment plan and meet the requirements in
119.25 subdivision 6, paragraph (b), clause (7).

119.26 (i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions
119.27 7 and 8.

119.28 (j) "Mental health behavioral aide services" means medically necessary one-on-one
119.29 activities performed by a mental health behavioral aide qualified according to section
119.30 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously
119.31 trained by a mental health professional, clinical trainee, or mental health practitioner and
119.32 as described in the child's individual treatment plan ~~and individual behavior plan~~. Activities
119.33 involve working directly with the child or child's family as provided in subdivision 9,
119.34 paragraph (b), clause (4).

120.1 (k) "Mental health certified family peer specialist" means a staff person who is qualified
120.2 according to section 245I.04, subdivision 12.

120.3 (l) "Mental health practitioner" means a staff person who is qualified according to section
120.4 245I.04, subdivision 4.

120.5 (m) "Mental health professional" means a staff person who is qualified according to
120.6 section 245I.04, subdivision 2.

120.7 (n) "Mental health service plan development" includes:

120.8 (1) development and revision of a child's individual treatment plan; and

120.9 (2) administering and reporting standardized outcome measurements approved by the
120.10 commissioner, as periodically needed to evaluate the effectiveness of treatment.

120.11 (o) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph
120.12 (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given
120.13 in section 245.4871, subdivision 15, for children under 18 years of age.

120.14 (p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision
120.15 11.

120.16 (q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions
120.17 to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had
120.18 been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate
120.19 for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills
120.20 acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for
120.21 children combine coordinated psychotherapy to address internal psychological, emotional,
120.22 and intellectual processing deficits, and skills training to restore personal and social
120.23 functioning. Psychiatric rehabilitation services establish a progressive series of goals with
120.24 each achievement building upon a prior achievement.

120.25 (r) "Skills training" means individual, family, or group training, delivered by or under
120.26 the supervision of a mental health professional, designed to facilitate the acquisition of
120.27 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate
120.28 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child
120.29 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or
120.30 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject
120.31 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

120.32 (s) "Standard diagnostic assessment" means the assessment described in section 245I.10,
120.33 subdivision 6.

121.1 (t) "Treatment supervision" means the supervision described in section 245I.06.

121.2 Sec. 29. Minnesota Statutes 2024, section 256B.0943, subdivision 6, is amended to read:

121.3 Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible
121.4 provider entity under this section, a provider entity must have a clinical infrastructure that
121.5 utilizes diagnostic assessment, individual treatment plans, service delivery, and individual
121.6 treatment plan review that are culturally competent, child-centered, and family-driven to
121.7 achieve maximum benefit for the client. The provider entity must review, and update as
121.8 necessary, the clinical policies and procedures every ~~three~~ two years, must distribute the
121.9 policies and procedures to staff initially and upon each subsequent update, and must train
121.10 staff accordingly.

121.11 (b) The clinical infrastructure written policies and procedures must include policies and
121.12 procedures for meeting the requirements in this subdivision:

121.13 (1) providing or obtaining a client's standard diagnostic assessment, including a standard
121.14 diagnostic assessment. When required components of the standard diagnostic assessment
121.15 are not provided in an outside or independent assessment or cannot be attained immediately,
121.16 the provider entity must determine the missing information within 30 days and amend the
121.17 child's standard diagnostic assessment or incorporate the information into the child's
121.18 individual treatment plan;

121.19 (2) developing an individual treatment plan;

121.20 (3) providing treatment supervision plans for staff according to section 245I.06. Treatment
121.21 supervision does not include the authority to make or terminate court-ordered placements
121.22 of the child. A treatment supervisor must be available for urgent consultation as required
121.23 by the individual client's needs or the situation;

121.24 (4) requiring a mental health professional to determine the level of supervision for a
121.25 behavioral health aide and to document and sign the supervision determination in the
121.26 behavioral health aide's supervision plan;

121.27 (5) ensuring the immediate accessibility of a mental health professional, clinical trainee,
121.28 or mental health practitioner to the behavioral aide during service delivery;

121.29 (6) providing service delivery that implements the individual treatment plan and meets
121.30 the requirements under subdivision 9; and

121.31 (7) individual treatment plan review. The review must determine the extent to which
121.32 the services have met each of the goals and objectives in the treatment plan. The review

122.1 must assess the client's progress and ensure that services and treatment goals continue to
122.2 be necessary and appropriate to the client and the client's family or foster family.

122.3 Sec. 30. Minnesota Statutes 2024, section 256B.0946, subdivision 4, is amended to read:

122.4 Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under
122.5 this section, a provider must develop and practice written policies and procedures for
122.6 children's intensive behavioral health services, consistent with subdivision 1, paragraph (b),
122.7 and comply with the following requirements in paragraphs (b) to (n).

122.8 (b) Each previous and current mental health, school, and physical health treatment
122.9 provider must be contacted to request documentation of treatment and assessments that the
122.10 eligible client has received. This information must be reviewed and incorporated into the
122.11 standard diagnostic assessment and team consultation and treatment planning review process.

122.12 (c) Each client receiving treatment must be assessed for a trauma history, and the client's
122.13 treatment plan must document how the results of the assessment will be incorporated into
122.14 treatment.

122.15 (d) The level of care assessment as defined in section 245I.02, subdivision 19, and
122.16 functional assessment as defined in section 245I.02, subdivision 17, must be updated at
122.17 least every 180 days or prior to discharge from the service, whichever comes first.

122.18 (e) Each client receiving treatment services must have an individual treatment plan that
122.19 is reviewed, evaluated, and approved every 180 days using the team consultation and
122.20 treatment planning process.

122.21 (f) Clinical care consultation must be provided in accordance with the client's individual
122.22 treatment plan.

122.23 (g) Each client must have a crisis plan within ten days of initiating services and must
122.24 have access to clinical phone support 24 hours per day, seven days per week, during the
122.25 course of treatment. The crisis plan must demonstrate coordination with the local or regional
122.26 mobile crisis intervention team.

122.27 (h) Services must be delivered and documented at least three days per week, equaling
122.28 at least six hours of treatment per week. If the mental health professional, client, and family
122.29 agree, service units may be temporarily reduced for a period of no more than 60 days in
122.30 order to meet the needs of the client and family, or as part of transition or on a discharge
122.31 plan to another service or level of care. The reasons for service reduction must be identified;
122.32 and documented, and included in the treatment plan or case file. Billing and payment are
122.33 prohibited for days on which no services are delivered and documented.

123.1 (i) Location of service delivery must be in the client's home, day care setting, school, or
123.2 other community-based setting that is specified on the client's individualized treatment plan.

123.3 (j) Treatment must be developmentally and culturally appropriate for the client.

123.4 (k) Services must be delivered in continual collaboration and consultation with the
123.5 client's medical providers and, in particular, with prescribers of psychotropic medications,
123.6 including those prescribed on an off-label basis. Members of the service team must be aware
123.7 of the medication regimen and potential side effects.

123.8 (l) Parents, siblings, foster parents, legal guardians, and members of the child's
123.9 permanency plan must be involved in treatment and service delivery unless otherwise noted
123.10 in the treatment plan.

123.11 (m) Transition planning for the child must be conducted starting with the first treatment
123.12 plan and must be addressed throughout treatment to support the child's permanency plan
123.13 and postdischarge mental health service needs.

123.14 (n) In order for a provider to receive the daily per-client encounter rate, at least one of
123.15 the services listed in subdivision 1, paragraph (b), clauses (1) to (3), must be provided. The
123.16 services listed in subdivision 1, paragraph (b), clauses (4) and (5), may be included as part
123.17 of the daily per-client encounter rate.

123.18 Sec. 31. Minnesota Statutes 2025 Supplement, section 256B.0947, subdivision 3a, is
123.19 amended to read:

123.20 Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative
123.21 mental health services, supports, and ancillary activities that are covered by a single daily
123.22 rate per client must include the following, as needed by the individual client:

123.23 (1) individual, family, and group psychotherapy;

123.24 (2) individual, family, and group skills training, as defined in section 256B.0943,
123.25 subdivision 1, paragraph (r);

123.26 (3) crisis planning as defined in section 245.4871, subdivision 9a;

123.27 (4) medication management provided by a ~~physician, an advanced practice registered~~
123.28 ~~nurse with certification in psychiatric and mental health care, or a physician assistant~~ qualified
123.29 provider;

123.30 (5) mental health case management as provided in section 256B.0625, subdivision 20;

123.31 (6) medication education services as defined in this section;

124.1 (7) care coordination by a client-specific lead worker assigned by and responsible to the
124.2 treatment team;

124.3 (8) psychoeducation of and consultation and coordination with the client's biological,
124.4 adoptive, or foster family and, in the case of a youth living independently, the client's
124.5 immediate nonfamilial support network;

124.6 (9) clinical consultation to a client's employer or school or to other service agencies or
124.7 to the courts to assist in managing the mental illness or co-occurring disorder and to develop
124.8 client support systems;

124.9 (10) coordination with, or performance of, crisis intervention and stabilization services
124.10 as defined in section 256B.0624;

124.11 (11) transition services;

124.12 (12) co-occurring substance use disorder treatment as defined in section 245I.02,
124.13 subdivision 11; and

124.14 (13) housing access support that assists clients to find, obtain, retain, and move to safe
124.15 and adequate housing. Housing access support does not provide monetary assistance for
124.16 rent, damage deposits, or application fees.

124.17 (b) The provider shall ensure and document the following by means of performing the
124.18 required function or by contracting with a qualified person or entity: client access to crisis
124.19 intervention services, as defined in section 256B.0624, and available 24 hours per day and
124.20 seven days per week.

124.21 **EFFECTIVE DATE.** This section is effective July 1, 2027, or upon federal approval,
124.22 whichever is later.

124.23 Sec. 32. Minnesota Statutes 2024, section 256B.0947, subdivision 5, is amended to read:

124.24 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services
124.25 must meet the standards in this section and chapter 245I as required in section 245I.011,
124.26 subdivision 5.

124.27 (b) The treatment team must have specialized training in providing services to the specific
124.28 age group of youth that the team serves. An individual treatment team must serve youth
124.29 who are: (1) at least eight years of age or older and under 16 years of age; ~~or~~; (2) at least
124.30 14 years of age or older and under 21 years of age; or (3) if a treatment team demonstrates
124.31 to the commissioner expertise in meeting the developmental and clinical needs of an
124.32 expanded age range, at least eight years of age and under 21 years of age.

125.1 (c) The treatment team for intensive nonresidential rehabilitative mental health services
125.2 comprises both permanently employed core team members and client-specific team members
125.3 as follows:

125.4 (1) Based on professional qualifications and client needs, clinically qualified core team
125.5 members are assigned on a rotating basis as the client's lead worker to coordinate a client's
125.6 care. The core team must comprise at least four full-time equivalent direct care staff and
125.7 must minimally include:

125.8 (i) a mental health professional who serves as team leader to provide administrative
125.9 direction and treatment supervision to the team;

125.10 (ii) ~~an advanced-practice registered nurse with certification in psychiatric or mental~~
125.11 ~~health care or a board-certified child and adolescent psychiatrist, either of which must be~~
125.12 ~~credentialed to prescribe medications; a psychiatric care provider who is credentialed to~~
125.13 prescribe medications and is either an advanced practice registered nurse with advanced
125.14 education and training in psychiatric and mental health care or a board-certified psychiatrist.
125.15 The psychiatric care provider must have demonstrated clinical experience and qualifications
125.16 for working with children and adolescents with serious mental illness and co-occurring
125.17 mental illness and substance use disorders;

125.18 (iii) a mental health certified peer specialist who is qualified according to section 245I.04,
125.19 subdivision 10, and is also a former children's mental health consumer; and

125.20 (iv) a co-occurring disorder specialist who meets the requirements under section
125.21 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the
125.22 provision of co-occurring disorder treatment to clients.

125.23 (2) The core team may also include any of the following:

125.24 (i) additional mental health professionals;

125.25 (ii) a vocational specialist;

125.26 (iii) an educational specialist with knowledge and experience working with youth
125.27 regarding special education requirements and goals, special education plans, and coordination
125.28 of educational activities with health care activities;

125.29 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

125.30 (v) a clinical trainee qualified according to section 245I.04, subdivision 6;

125.31 (vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;

126.1 (vii) a case management service provider, as defined in section 245.4871, subdivision
126.2 4;

126.3 (viii) a housing access specialist; ~~and~~

126.4 (ix) a family peer specialist as defined in subdivision 2, paragraph (j); and

126.5 (x) a registered nurse, as defined in section 148.171, subdivision 20.

126.6 (3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc
126.7 members not employed by the team who consult on a specific client and who must accept
126.8 overall clinical direction from the treatment team for the duration of the client's placement
126.9 with the treatment team and must be paid by the provider agency at the rate for a typical
126.10 session by that provider with that client or at a rate negotiated with the client-specific
126.11 member. Client-specific treatment team members may include:

126.12 (i) the mental health professional treating the client prior to placement with the treatment
126.13 team;

126.14 (ii) the client's current substance use counselor, if applicable;

126.15 (iii) a lead member of the client's individualized education program team or school-based
126.16 mental health provider, if applicable;

126.17 (iv) a representative from the client's health care home or primary care clinic, as needed
126.18 to ensure integration of medical and behavioral health care;

126.19 (v) the client's probation officer or other juvenile justice representative, if applicable;
126.20 and

126.21 (vi) the client's current vocational or employment counselor, if applicable.

126.22 (d) The treatment supervisor shall be an active member of the treatment team and shall
126.23 function as a practicing clinician at least on a part-time basis. The treatment team shall meet
126.24 with the treatment supervisor at least weekly to discuss recipients' progress and make rapid
126.25 adjustments to meet recipients' needs. The team meeting must include client-specific case
126.26 reviews and general treatment discussions among team members. Client-specific case
126.27 reviews and planning must be documented in the individual client's treatment record.

126.28 (e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
126.29 team position.

126.30 (f) The treatment team shall serve no more than 80 clients at any one time. Should local
126.31 demand exceed the team's capacity, an additional team must be established rather than
126.32 exceed this limit.

127.1 (g) Nonclinical staff shall have prompt access in person or by telephone to a mental
127.2 health practitioner, clinical trainee, or mental health professional. The provider shall have
127.3 the capacity to promptly and appropriately respond to emergent needs and make any
127.4 necessary staffing adjustments to ensure the health and safety of clients.

127.5 (h) The intensive nonresidential rehabilitative mental health services provider shall
127.6 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
127.7 as conducted by the commissioner, including the collection and reporting of data and the
127.8 reporting of performance measures as specified by contract with the commissioner.

127.9 (i) A regional treatment team may serve multiple counties.

127.10 Sec. 33. Minnesota Statutes 2025 Supplement, section 256L.03, subdivision 5, is amended
127.11 to read:

127.12 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to
127.13 children under the age of 21 and to American Indians as defined in Code of Federal
127.14 Regulations, title 42, section 600.5.

127.15 (b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered
127.16 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
127.17 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
127.18 services exempt from cost-sharing under state law. The cost-sharing changes described in
127.19 this paragraph shall not be implemented prior to January 1, 2016.

127.20 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements
127.21 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,
127.22 title 42, sections 600.510 and 600.520.

127.23 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic
127.24 disease must comply with the requirements of section 62Q.481.

127.25 (e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic
127.26 services or testing that a health care provider determines an enrollee requires after a
127.27 mammogram, as specified under section 62A.30, subdivision 5.

127.28 (f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to
127.29 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

127.30 (g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis
127.31 (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or
127.32 treatment of the human immunodeficiency virus (HIV).

128.1 (h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention,
128.2 crisis stabilization provided in a community setting, or crisis assessment as defined in section
128.3 256B.0624, subdivision 2.

128.4 Sec. 34. **REPEALER.**

128.5 (a) Minnesota Statutes 2024, section 256B.0759, subdivisions 2 and 5, are repealed.

128.6 (b) Minnesota Statutes 2025 Supplement, section 254B.052, subdivision 6, is repealed.

128.7 ARTICLE 7

128.8 HOMELESSNESS, HOUSING, AND SUPPORT SERVICES POLICY

128.9 Section 1. Minnesota Statutes 2024, section 245.991, subdivision 3, is amended to read:

128.10 Subd. 3. **Allowable grant activities.** Grantees must provide homeless outreach and case
128.11 management services. Projects may provide clinical assessment, habilitation and rehabilitation
128.12 services, community mental health services, substance use disorder treatment, housing
128.13 transition and sustaining services, or direct assistance funding. Services must be provided
128.14 to individuals with a serious mental illness, substance use disorder, or ~~with a co-occurring~~
128.15 ~~substance use disorder,~~ and who are homeless or at imminent risk of homelessness.

128.16 Individuals receiving homeless outreach services may be presumed eligible until a serious
128.17 mental illness can be verified.

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

128.19 Sec. 2. Minnesota Statutes 2024, section 245.992, subdivision 2, is amended to read:

128.20 Subd. 2. **Eligible beneficiaries.** Program activities must be provided to people with a
128.21 serious mental illness, substance use disorder, or ~~with a co-occurring substance use disorder,~~
128.22 who meet homeless criteria determined by the commissioner.

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

128.24 ARTICLE 8

128.25 MALTREATMENT OF VULNERABLE ADULTS

128.26 Section 1. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
128.27 to read:

128.28 Subd. 1a. **Adult protective services.** Adult protective services must receive referrals
128.29 from the common entry point and carry out lead investigative agency duties to investigate
128.30 for a determination of responsibility for maltreatment. When the county social services

129.1 agency is the lead investigative agency, or when the Department of Human Services or
129.2 Department of Health in the role of the lead investigative agency request adult protective
129.3 services, adult protective services must conduct assessments, develop services plans, and
129.4 implement interventions to safeguard adults who are vulnerable and suspected of experiencing
129.5 maltreatment. Adult protective services must conclude services following final determination
129.6 of maltreatment and the adult is assessed as safe. The Department of Human Services is the
129.7 state agency responsible for supervision of adult protective services administered by county
129.8 social services agencies.

129.9 Sec. 2. Minnesota Statutes 2024, section 626.557, subdivision 9, is amended to read:

129.10 Subd. 9. **Common entry point designation.** (a) The commissioner of human services
129.11 shall establish a common entry point. The common entry point is the unit responsible for
129.12 receiving the report of suspected maltreatment under this section.

129.13 (b) The common entry point must be available 24 hours per day to ~~take calls~~ accept
129.14 reports from reporters of suspected maltreatment and make required referrals for suspected
129.15 maltreatment of a vulnerable adult. The common entry point shall use a standard intake
129.16 form that includes:

129.17 (1) the time and date of the report;

129.18 (2) the name, relationship, and identifying and contact information for the person believed
129.19 to be a vulnerable adult and the individual or facility alleged responsible for maltreatment;

129.20 (3) the name, relationship, and contact information for the:

129.21 (i) reporter;

129.22 (ii) initial reporter, witnesses, and persons who may have knowledge about the
129.23 maltreatment; and

129.24 (iii) legal surrogate and persons who may provide support to the vulnerable adult;

129.25 (4) the basis of vulnerability for the vulnerable adult;

129.26 (5) the time, date, and location of the incident;

129.27 (6) the immediate safety risk to the vulnerable adult;

129.28 (7) a description of the suspected maltreatment;

129.29 (8) the impact of the suspected maltreatment on the vulnerable adult;

129.30 (9) whether a facility was involved and, if so, which agency licenses the facility;

- 130.1 (10) the actions taken to protect the vulnerable adult;
- 130.2 (11) the required notifications and referrals made by the common entry point; and
- 130.3 (12) whether the reporter wishes to receive notification of the disposition.
- 130.4 (c) The common entry point is not required to complete each item on the form prior to
130.5 dispatching the report to the appropriate lead investigative agency.
- 130.6 (d) The common entry point shall immediately report to a law enforcement agency any
130.7 incident in which there is reason to believe a crime has been committed.
- 130.8 (e) If a report is initially made to a law enforcement agency or a lead investigative agency,
130.9 those agencies shall take the report on the appropriate common entry point intake forms
130.10 and immediately forward a copy to the common entry point.
- 130.11 (f) The common entry point staff must receive training on how to screen and dispatch
130.12 reports efficiently and in accordance with this section.
- 130.13 (g) The commissioner of human services shall maintain a centralized database for the
130.14 collection of common entry point data, lead investigative agency data including maltreatment
130.15 report disposition, and appeals data. The common entry point shall have access to the
130.16 centralized database and must log the reports into the database.
- 130.17 (h) When appropriate, the common entry point staff must refer calls that do not allege
130.18 the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might
130.19 resolve the reporter's concerns.
- 130.20 (i) A common entry point must be operated in a manner that enables the commissioner
130.21 of human services to:
- 130.22 (1) track critical steps in the reporting, evaluation, referral, response, disposition, and
130.23 investigative process to ensure compliance with all requirements for all reports;
- 130.24 (2) maintain data to facilitate the production of aggregate statistical reports for monitoring
130.25 patterns of abuse, neglect, or exploitation;
- 130.26 (3) serve as a resource for the evaluation, management, and planning of preventative
130.27 and remedial services for vulnerable adults who have been subject to abuse, neglect, or
130.28 exploitation;
- 130.29 (4) set standards, priorities, and policies to maximize the efficiency and effectiveness
130.30 of the common entry point; and
- 130.31 (5) track and manage consumer complaints related to the common entry point.

131.1 (j) The commissioners of human services and health shall collaborate on the creation of
131.2 a system for referring reports to the lead investigative agencies. This system shall enable
131.3 the commissioner of human services to track critical steps in the reporting, evaluation,
131.4 referral, response, disposition, investigation, notification, determination, and appeal processes.

131.5 Sec. 3. Minnesota Statutes 2024, section 626.557, subdivision 9a, is amended to read:

131.6 Subd. 9a. **Evaluation and referral of reports made to common entry point.** (a) The
131.7 common entry point must screen the reports of alleged or suspected maltreatment for
131.8 immediate risk and make all necessary referrals ~~as follows~~ using the referral guidelines
131.9 established by the commissioner and the following:

131.10 (1) if the common entry point determines that there is an immediate need for emergency
131.11 adult protective services, the common entry point agency shall immediately notify the
131.12 appropriate county agency;

131.13 (2) if the report contains suspected criminal activity against a vulnerable adult, the
131.14 common entry point shall immediately notify the appropriate law enforcement agency;

131.15 (3) the common entry point shall refer all reports of alleged or suspected maltreatment
131.16 to the appropriate lead investigative agency as soon as possible, but in any event no longer
131.17 than two working days;

131.18 (4) if the report contains information about a suspicious death, the common entry point
131.19 shall immediately notify the appropriate law enforcement agencies, the local medical
131.20 examiner, and the ombudsman for mental health and developmental disabilities established
131.21 under section 245.92. Law enforcement agencies shall coordinate with the local medical
131.22 examiner and the ombudsman as provided by law; and

131.23 (5) for reports involving multiple locations or changing circumstances, the common
131.24 entry point shall determine the county agency responsible for emergency adult protective
131.25 services and the county responsible as the lead investigative agency, ~~using referral guidelines~~
131.26 ~~established by the commissioner.~~

131.27 (b) If the lead investigative agency receiving a report believes the report was referred
131.28 by the common entry point in error, the lead investigative agency shall immediately notify
131.29 the common entry point of the error, including the basis for the lead investigative agency's
131.30 belief that the referral was made in error. The common entry point shall review the
131.31 information submitted by the lead investigative agency and immediately refer the report to
131.32 the appropriate lead investigative agency using the referral guidelines established by the
131.33 commissioner.

132.1 Sec. 4. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to
132.2 read:

132.3 Subd. 11b. **County social services agency; responsibilities.** The county social services
132.4 agency is responsible for supervision of:

132.5 (1) intake decisions for initial disposition of the report;

132.6 (2) agency prioritization used to screen out an adult meeting eligibility for adult protective
132.7 services as vulnerable and maltreated;

132.8 (3) safety, assessment, and services plans;

132.9 (4) protective service interventions;

132.10 (5) use of guardianship and other involuntary interventions;

132.11 (6) final determination for maltreatment; and

132.12 (7) case closure decisions.

132.13 Sec. 5. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to
132.14 read:

132.15 Subd. 11c. **County social services agency; referrals.** (a) When the common entry point
132.16 refers a report to the county social services agency as the lead investigative agency or makes
132.17 a referral to the county social services agency for emergency adult protective services, or
132.18 when another lead investigative agency requests adult protective services from the county
132.19 social services agency for an adult referred to that lead investigative agency by the common
132.20 entry point, the county social services agency must use the data report system and
132.21 standardized decision and assessment tools provided by the commissioner of human services.
132.22 The information entered by the county social services agency into the data system and
132.23 standardized tools must be accessible to the Department of Human Services for the
132.24 department to meet federal requirements, evaluate consistent application of policy, review
132.25 quality of services and outcomes for adults, and meet requirements for background studies
132.26 and disqualification of individuals determined responsible for vulnerable adult maltreatment
132.27 under chapter 245C.

132.28 (b) The county social services agency must screen the report using the standardized tools
132.29 provided by the commissioner to determine:

132.30 (1) whether the referred adult meets adult protective services eligibility as potentially
132.31 vulnerable and maltreated under this section; and

133.1 (2) the response time required to initiate adult protective services.

133.2 (c) For reports referred by the common entry point for emergency adult protective
133.3 services, the county social services agency must immediately screen the report to determine
133.4 whether the adult should be accepted for emergency adult protective services. If the adult
133.5 is accepted for emergency adult protective services, the county social services agency must
133.6 immediately offer protective services to prevent further maltreatment and safeguard the
133.7 welfare of the vulnerable adult. Assessment of adults accepted by the county social services
133.8 agency for emergency protective services must be conducted in person by the agency or a
133.9 designee within 24 hours of the agency receiving the referral. When sexual or physical
133.10 abuse is suspected, the county social services agency must immediately arrange for and
133.11 make available to the vulnerable adult appropriate medical examination and services.

133.12 (d) For reports referred by the common entry point to the county as lead investigative
133.13 agency, the county social services agency must screen the report and make an initial
133.14 determination within seven calendar days following receipt of the report from the common
133.15 entry point on whether the adult should be accepted for adult protective services.

133.16 (e) For referrals made for adult protective services by the Department of Human Services
133.17 or the Department of Health in the applicable department's role as the lead investigative
133.18 agency responsible for reports made under this section, the county social services agency
133.19 must screen the report and determine within seven calendar days following receipt of referral
133.20 whether the adult should be accepted for adult protective services.

133.21 (f) If an adult meets eligibility requirements but is not accepted for adult protective
133.22 services based on local agency prioritization, the agency must document the reason for the
133.23 screening decision in the standardized tool provided by the commissioner.

133.24 Sec. 6. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to
133.25 read:

133.26 Subd. 11d. **County social services agency; assessments.** (a) For adults accepted into
133.27 adult protective services, the county social services agency must decide, prior to initiation
133.28 of assessment activities, if the agency must also conduct an investigation for final disposition
133.29 for responsibility of maltreatment in addition to the assessment for adult protective services.

133.30 (b) The county social services agency must conduct assessments concurrently with
133.31 investigations when: (1) the county is both the lead investigative agency and responsible
133.32 for making a final determination of responsibility for maltreatment; or (2) another lead

134.1 investigative agency responsible for the final determination of maltreatment requests
134.2 assistance from the county social services agency.

134.3 (c) The county social services agency must conduct an in-person assessment to initiate
134.4 adult protective services:

134.5 (1) within 24 hours of accepting a referral for emergency protective services;

134.6 (2) within 24 hours of making an initial disposition that the adult is in immediate need
134.7 of protection, unless an in-person response would endanger the safety of the adult; or

134.8 (3) within 72 hours but in no instance later than seven calendar days from the first
134.9 business day after receiving the report for adults accepted for adult protective services.

134.10 (d) The county social services agency must use the standardized decision, assessment,
134.11 and service planning tools provided by the commissioner with all vulnerable adults accepted
134.12 for adult protective services. The county social services agency must involve the vulnerable
134.13 adult in the assessment and service plan. The county social services agency must document
134.14 and update assessment and service plans consistent with significant changes in the vulnerable
134.15 adult's health and safety.

134.16 (e) The county social services agency must notify the vulnerable adult and, if applicable,
134.17 the guardian or health care agent of the vulnerable adult of the results of the assessment and
134.18 service plan, including but not limited to recommendations for protective services intervention
134.19 to stop or prevent maltreatment and to protect the vulnerable adult's health, safety, and
134.20 comfort. When necessary to prevent further maltreatment or safeguard the vulnerable adult,
134.21 the county social services agency may share the results of the assessment with the vulnerable
134.22 adult's primary supports.

134.23 Sec. 7. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to
134.24 read:

134.25 Subd. 11e. **County social services agency; investigations.** (a) The county social services
134.26 agency must investigate for a final disposition of responsibility for maltreatment for an
134.27 allegation of:

134.28 (1) abuse;

134.29 (2) financial abuse by a fiduciary;

134.30 (3) financial exploitation involving a nonfiduciary that may be criminal or that involved
134.31 force, coercion, harassment, deception, fraud, undue influence, or a scam;

134.32 (4) financial exploitation that involved another type of maltreatment;

135.1 (5) caregiver neglect by a paid caregiver or personal care assistance provider under
135.2 chapter 256B;

135.3 (6) caregiver neglect by an unpaid caregiver that resulted in intentional harm to the
135.4 vulnerable adult or involved another type of maltreatment; and

135.5 (7) a situation for which the county social services agency finds that a determination of
135.6 responsibility of maltreatment may safeguard a vulnerable adult or prevent further
135.7 maltreatment.

135.8 (b) The county social services agency must conduct an investigation for final disposition
135.9 of responsibility for maltreatment if the agency receives information during an assessment
135.10 that indicates the presence of any scenario listed in paragraph (a) or subdivision 11f.

135.11 Sec. 8. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to
135.12 read:

135.13 Subd. 11f. **County social services agency; self-neglect.** (a) The county social services
135.14 agency may determine that an allegation that does not result in a determination of
135.15 responsibility for maltreatment is:

135.16 (1) self-neglect;

135.17 (2) neglect by an unpaid caregiver that did not result in intentional harm to the vulnerable
135.18 adult and did not involve another type of alleged maltreatment; or

135.19 (3) financial exploitation by a nonfiduciary that is consistent with the choice of the adult
135.20 and not criminal or involving force, coercion, harassment, deception, fraud, undue influence,
135.21 a scam, or another type of alleged maltreatment.

135.22 (b) An allegation of self-neglect is a substantiated determination if the county social
135.23 services agency determines that adult protective services are needed.

135.24 Sec. 9. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to
135.25 read:

135.26 Subd. 11g. **County social services agency; initial contact.** (a) At the initial contact
135.27 with the vulnerable adult accepted by the county social services agency, the agency must
135.28 provide the vulnerable adult with information about the process for adult protective services
135.29 and the vulnerable adult's rights as an adult protective client.

135.30 (b) At initial contact, the county social services agency must inform the individual or
135.31 entity alleged responsible for maltreatment of the allegation in a manner consistent with

136.1 requirements under this section to protect the identity of the reporter. The interview with
136.2 the individual or entity alleged responsible for maltreatment may be postponed at the request
136.3 of a law enforcement agency or if the interview may endanger the safety of the vulnerable
136.4 adult.

136.5 Sec. 10. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
136.6 to read:

136.7 Subd. 11h. **County social services agency; agency authority.** (a) A county social
136.8 services agency may enter all facilities and business premises of a licensed provider to
136.9 inspect and copy records as part of an adult protective services assessment or investigation.
136.10 The licensed provider must provide the county social services agency access to not public
136.11 data as defined in section 13.02, subdivision 8a, and medical records under sections 144.291
136.12 to 144.298 that are maintained at the facilities and business premises to the extent that the
136.13 data and records are necessary to conduct the agency's investigation. The licensed provider
136.14 must provide the county social services agency access to all available sources of information
136.15 at the facilities and business premises, not only written records.

136.16 (b) When necessary in order to protect a vulnerable adult from serious harm from
136.17 maltreatment, the county social services agency may seek any of the following protective
136.18 services interventions:

136.19 (1) emergency protective services;

136.20 (2) participation of law enforcement or emergency medical services;

136.21 (3) authority from a court to remove an adult from the situation in which maltreatment
136.22 occurred;

136.23 (4) a restraining order or court order for removal of the perpetrator from the residence
136.24 of the vulnerable adult pursuant to section 518B.01;

136.25 (5) a referral for a financial transaction hold under chapter 45A or a protective
136.26 arrangement under this chapter or chapter 524;

136.27 (6) a referral for a representative payee;

136.28 (7) a referral to the prosecuting attorney for possible criminal prosecution of the
136.29 perpetrator under chapter 609;

136.30 (8) the appointment or replacement of a guardian or conservator pursuant to sections
136.31 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A when

137.1 maltreatment has been substantiated and when less restrictive interventions are not sufficient
137.2 to stop or reduce the risk of serious harm from maltreatment; and

137.3 (9) other interventions recommended by a multidisciplinary team under this section.

137.4 (c) The county social services agency may seek the protective services interventions
137.5 under paragraph (b) regardless of the vulnerable adult's voluntary or involuntary participation.

137.6 (d) The county social services agency may offer voluntary service interventions to
137.7 support the vulnerable adult or primary supports to stop, reduce the risk for, or prevent
137.8 subsequent maltreatment.

137.9 Sec. 11. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
137.10 to read:

137.11 Subd. 11i. **County social services agency; legal intervention.** (a) In proceedings under
137.12 sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to
137.13 petition for guardianship or conservatorship, a county employee must present the petition
137.14 with representation by the county attorney. The county must contract with or arrange for a
137.15 suitable person or organization to provide ongoing guardianship services. If the county
137.16 presents evidence to the court exercising probate jurisdiction that the county has made
137.17 diligent effort and no other suitable person can be found, a county employee may serve as
137.18 guardian or conservator.

137.19 (b) The county must not retaliate against the employee for any action taken on behalf
137.20 of the person subject to guardianship or conservatorship, even if the action is adverse to the
137.21 county's interests. Any person retaliated against in violation of this subdivision shall have
137.22 a cause of action against the county and is entitled to reasonable attorney fees and costs of
137.23 the action if the action is upheld by the court.

137.24 (c) The expenses of a legal intervention must be paid by the county in the case of indigent
137.25 persons under section 524.5-502 and chapter 563.

137.26 Sec. 12. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
137.27 to read:

137.28 Subd. 11j. **County social services agency; conflict of interest.** (a) A county that
137.29 identifies a potential conflict of interest under paragraph (c) related to an investigation,
137.30 assessment, or protective services intervention must coordinate with another county social
137.31 services agency to delegate the initial county's authority as the lead investigative agency to
137.32 remediate the potential conflict. County social services agencies must cooperate and accept

138.1 jurisdiction when an initial county social services agency identifies a potential conflict of
138.2 interest and requests the other county's assistance.

138.3 (b) The initial county must notify the commissioner of human services when no other
138.4 county is available to accept delegation of adult protective services duties. If the
138.5 commissioner is notified that no other county is available, the commissioner may use the
138.6 authority under subdivision 9a to determine the county social services agency responsible
138.7 as lead investigative agency and for adult protective services.

138.8 (c) A county social services agency employee or designee must not have:

138.9 (1) a personal or family relationship with a party in the investigation or assessment;

138.10 (2) a dual relationship, as defined in Code of Federal Regulations, title 45, section
138.11 1324.401, with the vulnerable adult;

138.12 (3) a personal financial interest or financial relationship with a provider receiving referrals
138.13 from the employee; or

138.14 (4) any other appearance of conflict of interest as determined by the county social services
138.15 agency.

138.16 Sec. 13. Minnesota Statutes 2024, section 626.557, subdivision 12b, is amended to read:

138.17 Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a
138.18 lead investigative agency, the county social ~~service~~ services agency shall maintain appropriate
138.19 records. Data collected by the county social ~~service~~ services agency under this section while
138.20 providing adult protective services are welfare data under section 13.46. Investigative data
138.21 collected under this section are confidential data on individuals or protected nonpublic data
138.22 as defined under section 13.02. Notwithstanding section 13.46, subdivision 1, paragraph
138.23 (a), data under this paragraph that are inactive investigative data on an individual who is a
138.24 vendor of services are private data on individuals, as defined in section 13.02. The identity
138.25 of the reporter may only be disclosed as provided in paragraph (c).

138.26 Data maintained by the common entry point are confidential data on individuals or
138.27 protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the
138.28 common entry point shall maintain data for three calendar years after date of receipt and
138.29 then destroy the data unless otherwise directed by federal requirements.

138.30 (b) The commissioners of health and human services shall prepare an investigation
138.31 memorandum for each report alleging maltreatment investigated under this section. County
138.32 social ~~service~~ services agencies must maintain private data on individuals but are not required

139.1 to prepare an investigation memorandum. During an investigation by the commissioner of
139.2 health or the commissioner of human services, data collected under this section are
139.3 confidential data on individuals or protected nonpublic data as defined in section 13.02.
139.4 Upon completion of the investigation, the data are classified as provided in clauses (1) to
139.5 (3) and paragraph (c).

139.6 (1) The investigation memorandum must contain the following data, which are public:

139.7 (i) the name of the facility investigated;

139.8 (ii) a statement of the nature of the alleged maltreatment;

139.9 (iii) pertinent information obtained from medical or other records reviewed;

139.10 (iv) the identity of the investigator;

139.11 (v) a summary of the investigation's findings;

139.12 (vi) statement of whether the report was found to be substantiated, inconclusive, false,

139.13 or that no determination will be made;

139.14 (vii) a statement of any action taken by the facility;

139.15 (viii) a statement of any action taken by the lead investigative agency; and

139.16 (ix) when a lead investigative agency's determination has substantiated maltreatment, a

139.17 statement of whether an individual, individuals, or a facility were responsible for the

139.18 substantiated maltreatment, if known.

139.19 The investigation memorandum must be written in a manner which protects the identity

139.20 of the reporter and of the vulnerable adult and may not contain the names or, to the extent

139.21 possible, data on individuals or private data listed in clause (2).

139.22 (2) Data on individuals collected and maintained in the investigation memorandum are

139.23 private data, including:

139.24 (i) the name of the vulnerable adult;

139.25 (ii) the identity of the individual alleged to be the perpetrator;

139.26 (iii) the identity of the individual substantiated as the perpetrator; and

139.27 (iv) the identity of all individuals interviewed as part of the investigation.

139.28 (3) Other data on individuals maintained as part of an investigation under this section

139.29 are private data on individuals upon completion of the investigation.

140.1 (c) The name of the reporter must be confidential. The subject of the report may compel
140.2 disclosure of the name of the reporter only with the consent of the reporter or upon a written
140.3 finding by a court that the report was false and there is evidence that the report was made
140.4 in bad faith. This subdivision does not alter disclosure responsibilities or obligations under
140.5 the Rules of Criminal Procedure, except that where the identity of the reporter is relevant
140.6 to a criminal prosecution, the district court shall do an in-camera review prior to determining
140.7 whether to order disclosure of the identity of the reporter.

140.8 (d) Notwithstanding section 138.163, data maintained under this section by the
140.9 commissioners of health and human services and county adult protective services must be
140.10 maintained under the following schedule and then destroyed unless otherwise directed by
140.11 federal requirements:

140.12 (1) data from reports determined to be false, maintained for three years after the finding
140.13 was made for reports under the jurisdiction of the Department of Human Services or the
140.14 Department of Health and five years after the finding was made for reports under the
140.15 jurisdiction of county adult protective services;

140.16 (2) data from reports determined to be inconclusive, maintained for four years after the
140.17 finding was made for reports under the jurisdiction of the Department of Human Services
140.18 or the Department of Health and five years after the finding was made for reports under the
140.19 jurisdiction of county adult protective services;

140.20 (3) data from reports determined to be substantiated, maintained for seven years after
140.21 the finding was made; and

140.22 (4) data from reports which were not investigated by a lead investigative agency and for
140.23 which there is no final disposition, maintained for three years from the date of the report
140.24 for reports under the jurisdiction of the Department of Human Services or the Department
140.25 of Health and five years from the date of the report for reports under the jurisdiction of
140.26 county adult protective services.

140.27 (e) The commissioners of health and human services shall annually publish on their
140.28 websites the number and type of reports of alleged maltreatment involving licensed facilities
140.29 reported under this section, the number of those requiring investigation under this section,
140.30 and the resolution of those investigations.

140.31 ~~(f) Each lead investigative agency must have a record retention policy.~~

140.32 ~~(g)~~ (f) Lead investigative agencies, county agencies responsible for adult protective
140.33 services, prosecuting authorities, and law enforcement agencies may exchange not public

141.1 data, as defined in section 13.02, with a tribal agency, facility, service provider, vulnerable
 141.2 adult, primary support person for a vulnerable adult, emergency management service,
 141.3 financial institution, medical examiner, state licensing board, federal or state agency, the
 141.4 ombudsman for long-term care, or the ombudsman for mental health and developmental
 141.5 disabilities, if the agency or authority providing the data determines that the data are pertinent
 141.6 and necessary to prevent further maltreatment of a vulnerable adult, to safeguard a vulnerable
 141.7 adult, or for an investigation under this section. Data collected under this section must be
 141.8 made available to prosecuting authorities and law enforcement officials, local county
 141.9 agencies, the commissioner of human services as the state Medicaid agency, and licensing
 141.10 agencies investigating the alleged maltreatment under this section. The lead investigative
 141.11 agency shall exchange not public data with the vulnerable adult maltreatment review panel
 141.12 established in section 256.021 if the data are pertinent and necessary for a review requested
 141.13 under that section. Notwithstanding section 138.17, upon completion of the review, not
 141.14 public data received by the review panel must be destroyed.

141.15 ~~(h)~~ (g) Each lead investigative agency shall keep records of the length of time it takes
 141.16 to complete its investigations.

141.17 ~~(i)~~ (h) A lead investigative agency may notify other affected parties and their authorized
 141.18 representative if the lead investigative agency has reason to believe maltreatment has occurred
 141.19 and determines the information will safeguard the well-being of the affected parties or dispel
 141.20 widespread rumor or unrest in the affected facility.

141.21 ~~(j)~~ (i) Under any notification provision of this section, where federal law specifically
 141.22 prohibits the disclosure of patient identifying information, a lead investigative agency may
 141.23 not provide any notice unless the vulnerable adult has consented to disclosure in a manner
 141.24 which conforms to federal requirements.

141.25 (j) When a county agency acting as the lead investigative agency is aware the person
 141.26 determined responsible for maltreatment is a guardian or conservator appointed under
 141.27 chapter 524, the county agency must share the final determination with the state judicial
 141.28 branch within 14 calendar days of the determination.

141.29 Sec. 14. Minnesota Statutes 2024, section 626.5572, subdivision 2, is amended to read:

141.30 Subd. 2. **Abuse.** "Abuse" means:

141.31 (a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate,
 141.32 or aiding and abetting a violation of:

141.33 (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

142.1 (2) the use of drugs to injure or facilitate crime as defined in section 609.235;

142.2 (3) the solicitation, inducement, and promotion of prostitution as defined in section
142.3 609.322; and

142.4 (4) criminal sexual conduct in the first through fifth degrees as defined in sections
142.5 609.342 to 609.3451.

142.6 A violation includes any action that meets the elements of the crime, regardless of
142.7 whether there is a criminal proceeding or conviction.

142.8 (b) Conduct which is not an accident or therapeutic conduct as defined in this section,
142.9 which produces or could reasonably be expected to produce physical pain or injury or
142.10 emotional distress including, but not limited to, the following:

142.11 (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable
142.12 adult;

142.13 (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable
142.14 adult or the treatment of a vulnerable adult which would be considered by a reasonable
142.15 person to be disparaging, derogatory, humiliating, harassing, or threatening; or

142.16 (3) use of any aversive or deprivation procedure, unreasonable confinement, or
142.17 involuntary seclusion, including the forced separation of the vulnerable adult from other
142.18 persons against the will of the vulnerable adult or the legal representative of the vulnerable
142.19 adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter
142.20 9544.

142.21 (c) Any contact with the vulnerable adult that is not therapeutic conduct and a reasonable
142.22 person would consider a sexual act or any nonconsensual sexual interaction with the
142.23 vulnerable adult, including but not limited to:

142.24 (1) making, viewing, or sharing sexual images or videos with or of the vulnerable adult;
142.25 and

142.26 (2) using oral, written, gestured, or electronic communication that is sexually harassing,
142.27 including but not limited to unwelcome sexual advances or requests for sexual favors.

142.28 ~~(e)~~ (d) Any sexual contact or penetration as defined in section 609.341, between a facility
142.29 staff person or a person providing services in the facility and a resident, patient, or client
142.30 of that facility.

142.31 ~~(d)~~ (e) The act of forcing, compelling, coercing, or enticing a vulnerable adult against
142.32 the vulnerable adult's will to perform services for the advantage of another.

143.1 ~~(e)~~ (f) For purposes of this section, a vulnerable adult is not abused for the sole reason
143.2 that the vulnerable adult or a person with authority to make health care decisions for the
143.3 vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section
143.4 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority
143.5 and within the boundary of reasonable medical practice, to any therapeutic conduct, including
143.6 any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition
143.7 of the vulnerable adult or, where permitted under law, to provide nutrition and hydration
143.8 parenterally or through intubation. This paragraph does not enlarge or diminish rights
143.9 otherwise held under law by:

143.10 (1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an
143.11 involved family member, to consent to or refuse consent for therapeutic conduct; or

143.12 (2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

143.13 ~~(f)~~ (g) For purposes of this section, a vulnerable adult is not abused for the sole reason
143.14 that the vulnerable adult, a person with authority to make health care decisions for the
143.15 vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or
143.16 prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of
143.17 medical care, provided that this is consistent with the prior practice or belief of the vulnerable
143.18 adult or with the expressed intentions of the vulnerable adult.

143.19 ~~(g)~~ (h) For purposes of this section, a vulnerable adult is not abused for the sole reason
143.20 that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional
143.21 dysfunction or undue influence, engages in consensual sexual contact with:

143.22 (1) a person, including a facility staff person, when a consensual sexual personal
143.23 relationship existed prior to the caregiving relationship; or

143.24 (2) a personal care attendant, regardless of whether the consensual sexual personal
143.25 relationship existed prior to the caregiving relationship.

143.26 Sec. 15. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision
143.27 to read:

143.28 Subd. 3a. **Adult protective services.** "Adult protective services" means an adult
143.29 protection program administered by a county social services agency under the authority of
143.30 the agency's governing body or delegated to a Tribal government by the commissioner of
143.31 human services to support adults referred for maltreatment to live safely and with dignity.

144.1 Sec. 16. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision
144.2 to read:

144.3 Subd. 3b. **Assessment.** "Assessment" means a structured process conducted by a county
144.4 social services agency to review the safety, strengths, and needs of an adult referred as
144.5 vulnerable and maltreated and accepted by the agency for adult protective services and to
144.6 develop a service plan to stop, prevent, and reduce risk of maltreatment for the adult using
144.7 standardized tools provided by the Department of Human Services.

144.8 Sec. 17. Minnesota Statutes 2024, section 626.5572, subdivision 9, is amended to read:

144.9 Subd. 9. **Financial exploitation.** "Financial exploitation" means:

144.10 (a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent
144.11 regulations, contractual obligations, documented consent by a competent person, or the
144.12 obligations of a responsible party under section 144.6501, a person:

144.13 (1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable
144.14 adult which results or is likely to result in detriment to the vulnerable adult; or

144.15 (2) fails to use the financial resources of the vulnerable adult to provide food, clothing,
144.16 shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the
144.17 failure results or is likely to result in detriment to the vulnerable adult.

144.18 (b) In the absence of legal authority a person:

144.19 (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

144.20 (2) obtains for the actor or another the performance of services by ~~a third person~~ the
144.21 vulnerable adult for the wrongful profit or advantage of the actor or another to the detriment
144.22 of the vulnerable adult;

144.23 (3) acquires possession or control of, or an interest in, funds or property of a vulnerable
144.24 adult through the use of undue influence, harassment, duress, deception, or fraud; or

144.25 (4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's
144.26 will to perform services for the profit or advantage of another.

144.27 (c) Nothing in this definition requires a facility or caregiver to provide financial
144.28 management or supervise financial management for a vulnerable adult except as otherwise
144.29 required by law.

145.1 Sec. 18. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision
145.2 to read:

145.3 Subd. 12a. **Investigation.** "Investigation" means activities for fact gathering conducted
145.4 by the lead investigative agency to make a final determination of maltreatment.

145.5 Sec. 19. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended
145.6 to read:

145.7 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
145.8 administrative agency responsible for investigating reports made under section 626.557.

145.9 (a) The Department of Health is the lead investigative agency for facilities or services
145.10 licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding
145.11 care homes, hospice providers, residential facilities that are also federally certified as
145.12 intermediate care facilities that serve people with developmental disabilities, or any other
145.13 facility or service not listed in this subdivision that is licensed or required to be licensed by
145.14 the Department of Health for the care of vulnerable adults. "Home care provider" has the
145.15 meaning provided in section 144A.43, subdivision 4, and applies when care or services are
145.16 delivered in the vulnerable adult's home.

145.17 (b) The Department of Human Services is the lead investigative agency for facilities or
145.18 services licensed or required to be licensed as adult day care, adult foster care, community
145.19 residential settings, programs for people with disabilities, EIDBI agencies, family adult day
145.20 services, mental health programs, mental health clinics, substance use disorder programs,
145.21 the Minnesota Sex Offender Program, or any other facility or service not listed in this
145.22 subdivision that is licensed or required to be licensed by the Department of Human Services.
145.23 The Department of Human Services is also the lead investigative agency for unlicensed
145.24 EIDBI agencies under section 256B.0949.

145.25 (c) The county social ~~service~~ services agency adult protective services or ~~its~~ the agency's
145.26 designee or a federally recognized Indian Tribe that entered into a contractual agreement
145.27 with the commissioner of human services to operate adult protective services is the lead
145.28 investigative agency for all other reports, including but not limited to reports involving
145.29 vulnerable adults receiving services from a personal care provider organization under section
145.30 256B.0659 or 256B.85.

145.31 Sec. 20. Minnesota Statutes 2024, section 626.5572, subdivision 17, is amended to read:

145.32 Subd. 17. **Neglect.** (a) "Neglect" means neglect by a caregiver or self-neglect.

146.1 (b) "Caregiver neglect" means the failure or omission by a caregiver to supply a
146.2 vulnerable adult with care or services, including but not limited to, food, clothing, shelter,
146.3 health care, or supervision which is:

146.4 (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or
146.5 mental health or safety, considering the physical and mental capacity or dysfunction of the
146.6 vulnerable adult; and

146.7 (2) which is not the result of an accident or therapeutic conduct.

146.8 (c) "Self-neglect" means neglect by a vulnerable adult of the vulnerable adult's own
146.9 food, clothing, shelter, health care, financial management, or other services that are not the
146.10 responsibility of a caregiver which a reasonable person would deem essential to obtain or
146.11 maintain the vulnerable adult's health, safety, or comfort.

146.12 (d) For purposes of this section, a vulnerable adult is not neglected for the sole reason
146.13 that:

146.14 (1) the vulnerable adult or a person with authority to make health care decisions for the
146.15 vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections
146.16 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with
146.17 that authority and within the boundary of reasonable medical practice, to any therapeutic
146.18 conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical
146.19 or mental condition of the vulnerable adult, or, where permitted under law, to provide
146.20 nutrition and hydration parenterally or through intubation; this paragraph does not enlarge
146.21 or diminish rights otherwise held under law by:

146.22 (i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an
146.23 involved family member, to consent to or refuse consent for therapeutic conduct; or

146.24 (ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; ~~or~~

146.25 (2) the vulnerable adult, a person with authority to make health care decisions for the
146.26 vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or
146.27 prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of
146.28 medical care, provided that this is consistent with the prior practice or belief of the vulnerable
146.29 adult or with the expressed intentions of the vulnerable adult;

146.30 (3) the vulnerable adult, who is not impaired in judgment or capacity by mental or
146.31 emotional dysfunction or undue influence, engages in consensual sexual contact with:

146.32 (i) a person including a facility staff person when a consensual sexual personal
146.33 relationship existed prior to the caregiving relationship; or

147.1 (ii) a personal care attendant, regardless of whether the consensual sexual personal
147.2 relationship existed prior to the caregiving relationship; ~~or~~

147.3 (4) an individual makes an error in the provision of therapeutic conduct to a vulnerable
147.4 adult which does not result in injury or harm which reasonably requires medical or mental
147.5 health care; or

147.6 (5) an individual makes an error in the provision of therapeutic conduct to a vulnerable
147.7 adult that results in injury or harm, which reasonably requires the care of a physician, and:

147.8 (i) the necessary care is provided in a timely fashion as dictated by the condition of the
147.9 vulnerable adult;

147.10 (ii) if after receiving care, the health status of the vulnerable adult can be reasonably
147.11 expected, as determined by the attending physician, to be restored to the vulnerable adult's
147.12 preexisting condition;

147.13 (iii) the error is not part of a pattern of errors by the individual;

147.14 (iv) if in a facility, the error is immediately reported as required under section 626.557,
147.15 and recorded internally in the facility;

147.16 (v) if in a facility, the facility identifies and takes corrective action and implements
147.17 measures designed to reduce the risk of further occurrence of this error and similar errors;
147.18 and

147.19 (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently
147.20 documented for review and evaluation by the facility and any applicable licensing,
147.21 certification, and ombudsman agency.

147.22 (e) Nothing in this definition requires a caregiver, if regulated, to provide services in
147.23 excess of those required by the caregiver's license, certification, registration, or other
147.24 regulation.

147.25 (f) If the findings of an investigation by a lead investigative agency result in a
147.26 determination of substantiated maltreatment for the sole reason that the actions required of
147.27 a facility under paragraph (d), clause (5), item (iv), (v), or (vi), were not taken, then the
147.28 facility is subject to a correction order. An individual will not be found to have neglected
147.29 or maltreated the vulnerable adult based solely on the facility's not having taken the actions
147.30 required under paragraph (d), clause (5), item (iv), (v), or (vi). This must not alter the lead
147.31 investigative agency's determination of mitigating factors under section 626.557, subdivision
147.32 9c, paragraph (f).

148.1 Sec. 21. **REPEALER.**

148.2 Minnesota Statutes 2024, section 626.557, subdivision 10, is repealed.

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

148.4 **ARTICLE 9**

148.5 **MISCELLANEOUS POLICY**

148.6 Section 1. Minnesota Statutes 2024, section 62Q.75, subdivision 4, is amended to read:

148.7 Subd. 4. **Claims adjustment timeline.** (a) Once a clean claim, as defined in section
148.8 62Q.75, subdivision 1, has been paid, the contract must provide a 12-month deadline on all
148.9 adjustments to and recoupments of the payment with the exception of payments related to
148.10 ~~coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases~~
148.11 of fraud and abuse.

148.12 (b) Paragraph (a) shall not apply to pharmacy contracts entered into between or on behalf
148.13 of health plan companies.

148.14 **EFFECTIVE DATE.** This section is effective January 1, 2027, and applies to all
148.15 contracts effective on or after that date.

148.16 Sec. 2. Minnesota Statutes 2025 Supplement, section 245C.03, subdivision 6, is amended
148.17 to read:

148.18 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
148.19 **seniors and individuals with disabilities and ~~providers of housing stabilization~~**
148.20 **services.** (a) For providers of services specified in the federally approved home and
148.21 community-based waiver plans under section 256B.4912 ~~and providers of housing~~
148.22 ~~stabilization services under section 256B.051~~, the commissioner shall conduct background
148.23 studies on any individual who is an owner with at least a five percent ownership stake in
148.24 the provider, an operator of the provider, or an employee or volunteer for the provider who
148.25 has direct contact with people receiving the services. The individual studied must meet the
148.26 requirements of this chapter prior to providing waiver services and as part of ongoing
148.27 enrollment.

148.28 (b) The requirements in paragraph (a) apply to consumer-directed community supports
148.29 under section 256B.4911.

148.30 (c) For purposes of this section, "operator" includes but is not limited to a managerial
148.31 officer who oversees the billing, management, or policies of the services provided.

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

149.2 Sec. 3. Minnesota Statutes 2025 Supplement, section 245C.10, subdivision 6, is amended
149.3 to read:

149.4 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
149.5 **seniors and individuals with disabilities and providers of housing stabilization**
149.6 **services.** The commissioner shall recover the cost of background studies initiated by
149.7 unlicensed home and community-based waiver providers of service to seniors and individuals
149.8 with disabilities under section 256B.4912 ~~and providers of housing stabilization services~~
149.9 ~~under section 256B.051~~ through a fee of no more than \$44 per study.

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

149.11 Sec. 4. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
149.12 to read:

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

149.24 (b) The commissioner shall revalidate:

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

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

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

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

149.31 (c) The commissioner shall conduct revalidation as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

151.9 (h) The commissioner may revoke the enrollment of an ordering or rendering provider
151.10 for a period of not more than one year, if the provider fails to maintain and, upon request
151.11 from the commissioner, provide access to documentation relating to written orders or requests
151.12 for payment for durable medical equipment, certifications for home health services, or
151.13 referrals for other items or services written or ordered by such provider, when the
151.14 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
151.15 to maintain documentation or provide access to documentation on more than one occasion.
151.16 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
151.17 under the provisions of section 256B.064.

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

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

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

151.27 (3) serves primarily a pediatric population.

151.28 (j) As a condition of enrollment in medical assistance, the commissioner shall require
151.29 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
151.30 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
151.31 Services, its agents, or its designated contractors and the state agency, its agents, or its
151.32 designated contractors to conduct unannounced on-site inspections of any provider location.
151.33 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a

152.1 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
152.2 and standards used to designate Medicare providers in Code of Federal Regulations, title
152.3 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
152.4 The commissioner's designations are not subject to administrative appeal.

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

152.11 (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable
152.12 medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
152.13 meeting the durable medical equipment provider and supplier definition in clause (3),
152.14 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
152.15 annually renewed and designates the Minnesota Department of Human Services as the
152.16 obligee, and must be submitted in a form approved by the commissioner. For purposes of
152.17 this clause, the following medical suppliers are not required to obtain a surety bond: a
152.18 federally qualified health center, a home health agency, the Indian Health Service, a
152.19 pharmacy, and a rural health clinic.

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

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

153.1 (m) The Department of Human Services may require a provider to purchase a surety
 153.2 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment
 153.3 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
 153.4 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
 153.5 provider or category of providers is designated high-risk pursuant to paragraph (f) and as
 153.6 per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an
 153.7 amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
 153.8 immediately preceding 12 months, whichever is greater. The surety bond must name the
 153.9 Department of Human Services as an obligee and must allow for recovery of costs and fees
 153.10 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
 153.11 maintains a surety bond under the requirements in section ~~256B.051~~, 256B.0659, 256B.0701,
 153.12 or 256B.85.

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

153.14 Sec. 5. Minnesota Statutes 2024, section 256B.0658, is amended to read:

153.15 **256B.0658 HOUSING ACCESS GRANTS.**

153.16 **Subdivision 1. Establishment.** The commissioner of human services shall award through
 153.17 a competitive process contracts for grants to public and private agencies to support and
 153.18 assist individuals with a disability ~~as defined in section 256B.051, subdivision 2, paragraph~~
 153.19 ~~(e)~~, to access housing.

153.20 **Subd. 2. Definition.** (a) For the purposes of this section, the term defined in this
 153.21 subdivision has the meaning given.

153.22 **(b) "Individual with a disability" means:**

153.23 **(1) an individual who is aged, blind, or disabled as determined by the criteria under**
 153.24 **sections 216(i)(1) and 221 of the Social Security Act; or**

153.25 **(2) an individual who meets a category of eligibility under section 256D.05, subdivision**
 153.26 **1, paragraph (a), clause (1), (4), (5) to (8), or (13).**

153.27 **Subd. 3. Allowable uses of grant funds.** Grants may be awarded to agencies that may
 153.28 include, but are not limited to, the following supports: assessment to ensure suitability of
 153.29 housing, accompanying an individual to look at housing, filling out applications and rental
 153.30 agreements, meeting with landlords, helping with Section 8 or other program applications,
 153.31 helping to develop a budget, obtaining furniture and household goods, if necessary, and
 153.32 assisting with any problems that may arise with housing.

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

154.2 Sec. 6. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended
154.3 to read:

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

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

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

154.10 ~~(3) demonstrates compliance with federal and state laws and policies for housing~~
154.11 ~~stabilization services as determined by the commissioner;~~

154.12 ~~(4)~~(3) complies with background study requirements under chapter 245C and maintains
154.13 documentation of background study requests and results;

154.14 ~~(5)~~(4) provides at the time of enrollment, reenrollment, and revalidation in a format
154.15 determined by the commissioner, proof of surety bond coverage for each business location
154.16 providing services. Upon new enrollment, or if the provider's medical assistance revenue
154.17 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
154.18 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
154.19 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
154.20 must be in a form approved by the commissioner, must be renewed annually, and must
154.21 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain
154.22 monetary recovery or sanctions from a surety bond must occur within six years from the
154.23 date the debt is affirmed by a final agency decision. An agency decision is final when the
154.24 right to appeal the debt has been exhausted or the time to appeal has expired under section
154.25 256B.064;

154.26 ~~(6)~~(5) ensures all controlling individuals and employees of the agency complete annual
154.27 vulnerable adult training;

154.28 ~~(7)~~(6) completes compliance training as required under subdivision 11; and

154.29 ~~(8)~~(7) complies with the habitability inspection requirements in subdivision 13.

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

155.1 Sec. 7. Minnesota Statutes 2024, section 256L.03, subdivision 1, is amended to read:

155.2 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
155.3 services reimbursed under chapter 256B, with the exception of special education services,
155.4 home care nursing services, nonemergency medical transportation services, personal care
155.5 assistance and case management services, community first services and supports under
155.6 section 256B.85, behavioral health home services under section 256B.0757, ~~housing~~
155.7 ~~stabilization services under section 256B.051~~, and nursing home or intermediate care facilities
155.8 services.

155.9 (b) Covered health services shall be expanded as provided in this section.

155.10 (c) For the purposes of covered health services under this section, "child" means an
155.11 individual younger than 19 years of age.

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

155.13 Sec. 8. **DIRECTION TO COMMISSIONER; RULEMAKING.**

155.14 The commissioner of human services must amend Minnesota Rules, part 9505.2165,
155.15 subpart 4, item C, to remove the citation to United States Code, title 42, section
155.16 1320a-7b(b)(3)(D), and insert a citation to United States Code, title 42, section 1320a-7b(b).
155.17 The commissioner may use the procedure under Minnesota Statutes, section 14.388,
155.18 subdivision 1, clause (3), for changes to Minnesota Rules pursuant to this section. Minnesota
155.19 Statutes, section 14.386, does not apply to rules adopted pursuant to this section except as
155.20 provided under Minnesota Statutes, section 14.388.

155.21 Sec. 9. **DIRECTION TO COMMISSIONER; UNREDACTED INITIAL OPTUM**
155.22 **REPORTS.**

155.23 (a) For purposes of this section, "initial Optum reports" means the reports produced by
155.24 Optum, Inc., under contract with the Department of Human Services and announced in the
155.25 news release from the department on February 6, 2026.

155.26 (b) Notwithstanding any law to the contrary, upon a joint request by the chairs and
155.27 ranking minority members of a legislative committee with jurisdiction over human services
155.28 policy and finance, the commissioner of human services must immediately release the initial
155.29 Optum reports to the members of that legislative committee in the reports' entirety without
155.30 redactions or edits, except for redactions requested by Optum to protect proprietary
155.31 information. Legislators or legislative staff who receive initial Optum reports under this

156.1 section must not disseminate or publicize any not public data, as defined in Minnesota
156.2 Statutes, section 13.02, subdivision 8a, that the reports contain.

156.3 **EFFECTIVE DATE.** This section is effective 14 days following final enactment.

156.4 Sec. 10. **OPTUM PROHIBITED FROM DISSEMINATING PRIVATE DATA.**

156.5 Optum, Inc., must not sell, share, or disseminate any private data on individuals, as
156.6 defined in Minnesota Statutes, section 13.02, subdivision 12, that Optum receives under or
156.7 incidental to Optum's contract or engagement with the Department of Human Services
156.8 pursuant to the governor's Executive Order No. 25-10.

156.9 Sec. 11. **REPEALER.**

156.10 (a) Minnesota Statutes 2024, section 256B.051, subdivisions 1, 4, and 7, are repealed.

156.11 (b) Minnesota Statutes 2025 Supplement, section 256B.051, subdivisions 2, 3, 5, 6, 6a,
156.12 6b, 8, 9, and 10, are repealed.

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

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254B.052 PEER RECOVERY SUPPORT SERVICES REQUIREMENTS.

Subd. 6. **Monetary recovery.** Peer recovery support services not provided in accordance with this section are subject to monetary recovery under section 256B.064 as money improperly paid.

256B.051 HOUSING STABILIZATION SERVICES.

Subdivision 1. **Purpose.** Housing stabilization services are established to provide housing stabilization services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide housing stabilization services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section.

(c) "At-risk of homelessness" means (1) an individual that is faced with a set of circumstances likely to cause the individual to become homeless, or (2) an individual previously homeless, who will be discharged from a correctional, medical, mental health, or treatment center, who lacks sufficient resources to pay for housing and does not have a permanent place to live.

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

(e) "Employee of an agency" or "employee" means any person who is employed by an agency temporarily, part time, or full time and who performs work for at least 80 hours in a year for that agency in Minnesota. Employee does not include an independent contractor.

(f) "Homeless" means an individual or family lacking a fixed, adequate nighttime residence.

(g) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria used by the title 11 program of the Social Security Act, United States Code, title 42, section 416, paragraph (i), item (1); or

(2) an individual who meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

(h) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause (3), and the Minnesota Security Hospital as defined in section 253.20.

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing stabilization services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has income at or below 150 percent of the federal poverty level;

(4) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(5) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301 (c); and

(6) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under chapter 256S or section 256B.092 or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

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Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, subdivisions 17 to 21, 23, 24, and 29 to 31, using a format established by the commissioner;

(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

Subd. 5. **Housing stabilization services.** (a) Housing stabilization services include housing transition services, housing and tenancy sustaining services, housing consultation services, and housing transition costs.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) Housing consultation services assist an individual with developing a person-centered plan when the individual is not eligible to receive person-centered planning through any other service.

(e) Housing transition costs are available to persons transitioning from a provider-controlled setting to the person's own home and include:

(1) security deposits; and

(2) essential furnishings and supplies.

Subd. 6. **Agency qualifications and duties.** An agency is eligible for reimbursement under this section only if the agency:

(1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 6a;

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

(3) demonstrates compliance with federal and state laws and policies for housing stabilization services as determined by the commissioner;

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

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(5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety bond of \$50,000. If the provider's medical assistance revenue in the previous year is over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) directly provides housing stabilization services using employees of the agency and not by using a subcontractor or reporting agent;

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

(8) completes compliance training as required under subdivision 6b.

Subd. 6a. Pre-enrollment risk assessment. (a) Prior to enrolling a housing stabilization services agency, the commissioner must complete a pre-enrollment risk assessment of the agency seeking to enroll to confirm the agency's eligibility and the agency's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential agency's history of performing services similar to those required by this section;

(2) whether the services require the potential agency to perform duties at a significantly increased scale and, if so, whether the potential agency has the capability and organizational capacity to do so;

(3) the potential agency's financial information and internal controls; and

(4) the potential agency's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential agency does not have a history of performing similar duties, the potential agency does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential agency ineligible and deny or rescind enrollment. A potential agency may appeal a decision regarding its eligibility in writing within 30 business days. The commissioner must notify each potential agency of the commissioner's final decision regarding its eligibility.

(c) This subdivision is effective July 1, 2025. Any housing stabilization services provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Subd. 6b. Requirements for provider enrollment. (a) Effective January 1, 2027, to enroll as a housing stabilization services provider agency, an agency must require all owners of the agency who are active in the day-to-day management and operations of the agency and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

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

(2) enrollment requirements;

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

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

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

(c) Any housing stabilization services provider agency enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

Subd. 7. Housing support supplemental service rates. Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing stabilization services under this section.

Subd. 8. Documentation requirements. (a) An agency must document delivery of all services. The agency must collect and maintain the required information either electronically or in paper form and must produce the documents containing the information upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the full name of the service recipient;

(2) the date the documentation occurred;

(3) the day, month, and year the service was provided;

(4) the start and stop times with a.m. and p.m. designations, except for housing consultation services;

(5) the service name or description of the service provided for each date of service;

(6) the name, signature, and title, if any, of the employee of the agency that provided the service. If the service is provided by multiple employees, the agency may designate an employee responsible for verifying services and completing the documentation required by this paragraph;

(7) the signature of the service recipient and a statement that the recipient's signature is verification of the accuracy of the service documentation; and

(8) a statement that it is a federal crime to provide false information on housing stabilization services billings for medical assistance payments.

Subd. 9. Service limits. (a) Housing stabilization services must not exceed the limits in clauses (1) to (4):

(1) housing transition services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing and tenancy sustaining services;

(2) housing and tenancy sustaining services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing transition services;

(3) housing consultation services are available once annually per recipient and must be provided in person. Additional sessions of housing consultation services may be authorized by the commissioner if the recipient becomes homeless, the recipient experiences a significant change in condition that impacts the recipient's housing, or the recipient requests an update or change to the recipient's plan; and

(4) housing transition costs are limited to \$3,000 annually.

(b) Remote support cannot be used for more than a total of 20 percent of all housing transition services and housing and tenancy sustaining services provided to a recipient in a calendar month and is limited to audio-only and accessible video-based platforms. A recipient may refuse, stop, or suspend the use of remote support at any time.

Subd. 10. Service limit exceptions. If a recipient requires services exceeding the limits described in subdivision 9, a provider may request authorization for additional hours in a format prescribed

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by the commissioner. Requests must specify the number of additional hours being requested to meet the recipient's needs and include sufficient documentation to justify the increase to billable hours. Exceptions to service limits are not allowed on the sole basis of changing providers and are limited to recipients who:

(1) become or are at risk of becoming homeless or institutionalized due to a significant change in condition;

(2) have a history of long-term homelessness;

(3) have a history of domestic violence; or

(4) have a criminal background that is a barrier to obtaining housing.

256B.0759 SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.

Subd. 2. **Provider participation.** (a) Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter, are licensed as a hospital under sections 144.50 to 144.581, and provide only ASAM 3.7 medically monitored inpatient level of care are not required to enroll as demonstration project providers. Programs meeting these criteria must submit evidence of providing the required level of care to the commissioner to be exempt from enrolling in the demonstration.

(d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(f) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with Tribal Nations to discuss participation in the substance use disorder demonstration project.

(g) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

(1) the provider attests that during the time period for which the provider is seeking the rate enhancement, the provider took meaningful steps in their plan approved by the commissioner to meet the demonstration project requirements in subdivision 3; and

(2) the provider submits attestation and evidence, including all information requested by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in a format required by the commissioner.

(h) The commissioner may recoup any rate enhancements paid under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

256B.5012 ICF/DD PAYMENT SYSTEM IMPLEMENTATION.

Subd. 4. **ICF/DD rate increases beginning July 1, 2001, and July 1, 2002.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 3.5 percent. Of this adjustment, two-thirds must be used as provided under paragraph (b) and one-third must be used for operating costs.

(b) The adjustment under this paragraph must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase must be used only for wage and benefit increases implemented on or after the first day of the rate year and must not be used for increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding June 30. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the payment rate adjustment provided under paragraph (b). The application must be made to the commissioner and contain a plan by which the facility will distribute the adjustment in paragraph (b) to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2002, and March 31, 2003, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Subd. 5. **Rate increase effective June 1, 2003.** For rate periods beginning on or after June 1, 2003, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by \$3 per day. The increase shall not be subject to any annual percentage increase.

Subd. 6. **ICF/DD rate increases October 1, 2005, and October 1, 2006.** (a) For the rate periods beginning October 1, 2005, and October 1, 2006, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 2.2553 percent.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except for administrative and central office employees. 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date. The wage adjustment eligible employees may receive may vary based on merit, seniority, or other factors determined by the provider.

(c) For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in paragraph (a) multiplied by the total payment rate, including variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the portion of the payment rate adjustment provided under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the

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commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2006, and December 31, 2006, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Subd. 7. ICF/DD rate increases effective October 1, 2007, and October 1, 2008. (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2008. For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in this paragraph multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12. A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(b) Seventy-five percent of the money resulting from the rate adjustments under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

- (1) the administrator;
- (2) persons employed in the central office of a corporation that has an ownership interest in the facility or exercises control over the facility; and
- (3) persons paid by the facility under a management contract.

(c) Two-thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustments, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation-related costs all costs for:

- (1) wages and salaries;
- (2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;
- (3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and
- (4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustments under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to facilities effective October 1 of each year.

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(f) Facilities may apply for the portion of the rate adjustments under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustments, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustments. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in clause (1);

(3) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, email address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with requirements in clauses (1) to (4):

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the facility's payroll period that includes October 1 of each year shall be allowed if they were not used in the prior year's application and they meet the requirements of paragraphs (b) and (c);

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1 of the year in which the rate adjustments are effective and prior to April 1 of the following year; and

(4) for facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, as regards members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustments under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustments shall be effective October 1 of each year. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

Subd. 8. ICF/DD rate decreases effective July 1, 2009. Effective July 1, 2009, the commissioner shall decrease each facility reimbursed under this section operating payment adjustments equal to 2.58 percent of the operating payment rates in effect on June 30, 2009. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in subdivision 7.

Subd. 9. ICF/DD rate increase effective July 1, 2011; Clearwater County. Effective July 1, 2011, the commissioner shall increase the daily rate to \$138.23 at an intermediate care facility for

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the developmentally disabled located in Clearwater County and classified as a class A facility with 15 beds.

Subd. 10. **ICF/DD rate decrease effective July 1, 2011; exception for Clearwater County.** For each facility reimbursed under this section, except for a facility located in Clearwater County and classified as a class A facility with 15 beds, the commissioner shall decrease operating payment rates equal to 0.095 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 11. **ICF/DD rate decrease effective July 1, 2011.** For each facility reimbursed under this section, the commissioner shall decrease operating payments equal to 1.5 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 12. **ICF/DD rate increase effective July 1, 2013.** For each facility reimbursed under this section, the commissioner shall increase operating payments equal to one-half percent of the operating payment rates in effect on June 30, 2013. For each facility, the commissioner shall apply the rate increase, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 14. **Rate increase effective June 1, 2013.** For rate periods beginning on or after June 1, 2013, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by \$7.81 per day. The increase shall not be subject to any annual percentage increase.

Subd. 15. **ICF/DD rate increases effective April 1, 2014.** (a) Notwithstanding subdivision 12, for each facility reimbursed under this section, for the rate period beginning April 1, 2014, the commissioner shall increase operating payments equal to one percent of the operating payment rates in effect on March 31, 2014.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate, but excluding the property-related payment rate in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 16. **ICF/DD rate increases effective July 1, 2014.** (a) For the rate period beginning July 1, 2014, the commissioner shall increase operating payments for each facility reimbursed under this section equal to five percent of the operating payment rates in effect on June 30, 2014.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate in effect on June 30, 2014. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

(c) To receive the rate increase under paragraph (a), each facility reimbursed under this section must submit to the commissioner documentation that identifies a quality improvement project that the facility will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must:

- (1) improve the quality of life of intermediate care facility residents in a meaningful way;
- (2) improve the quality of services in a measurable way; or
- (3) deliver good quality service more efficiently while using the savings to enhance services for the participants served.

(d) For a facility that fails to submit the documentation described in paragraph (c) by a date or in a format specified by the commissioner, the commissioner shall reduce the facility's rate by one percent effective January 1, 2015.

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(e) Facilities that receive a rate increase under this subdivision shall use 80 percent of the additional revenue to increase compensation-related costs for employees directly employed by the facility on or after July 1, 2014, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and

(2) persons paid by the facility under a management contract.

This requirement is subject to audit by the commissioner.

(f) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (i).

(g) For public employees under a collective bargaining agreement, the increase for wages and benefits is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a facility under paragraph (e) for pay increases for public employees must be used only for pay increases implemented between July 1, 2014, and August 1, 2014.

(h) For a facility that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under paragraph (i), in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the facility shall be deemed to have met all the requirements of this subdivision in regard to the members of the bargaining unit. Upon request, the facility shall produce the letter of acceptance for the commissioner.

(i) A facility that receives a rate adjustment under paragraph (a) that is subject to paragraph (e) shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the facility expects to receive that is subject to the requirements of paragraph (e), including how that money will be distributed to increase compensation for employees. The commissioner may recover funds from a facility that fails to comply with this requirement.

(j) By January 1, 2015, the facility shall post the distribution plan required under paragraph (i) for a period of at least six weeks in an area of the facility's operation to which all eligible employees have access and shall provide instructions for employees who do not believe they have received the wage and other compensation-related increases specified in the distribution plan. The instructions must include a mailing address, email address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative.

626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS.

Subd. 10. **Duties of county social service agency.** (a) When the common entry point refers a report to the county social service agency as the lead investigative agency or makes a referral to the county social service agency for emergency adult protective services, or when another lead investigative agency requests assistance from the county social service agency for adult protective services, the county social service agency shall immediately assess and offer emergency and continuing protective social services for purposes of preventing further maltreatment and for safeguarding the welfare of the maltreated vulnerable adult. The county shall use standardized tools and the data system made available by the commissioner. The information entered by the county into the standardized tool must be accessible to the Department of Human Services. In cases of suspected sexual abuse, the county social service agency shall immediately arrange for and make available to the vulnerable adult appropriate medical examination and treatment. When necessary in order to protect the vulnerable adult from further harm, the county social service agency shall seek authority to remove the vulnerable adult from the situation in which the maltreatment occurred. The county social service agency may also investigate to determine whether the conditions which resulted in the reported maltreatment place other vulnerable adults in jeopardy of being maltreated and offer protective social services that are called for by its determination.

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(b) Within five business days of receipt of a report screened in by the county social service agency for investigation, the county social service agency shall determine whether, in addition to an assessment and services for the vulnerable adult, to also conduct an investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

(c) The county social service agency must investigate for a final disposition the individual or facility alleged to have maltreated a vulnerable adult for each report accepted as lead investigative agency involving an allegation of abuse, caregiver neglect that resulted in harm to the vulnerable adult, financial exploitation that may be criminal, or an allegation against a caregiver under chapter 256B.

(d) An investigating county social service agency must make a final disposition for any allegation when the county social service agency determines that a final disposition may safeguard a vulnerable adult or may prevent further maltreatment.

(e) If the county social service agency learns of an allegation listed in paragraph (c) after the determination in paragraph (a), the county social service agency must change the initial determination and conduct an investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

(f) County social service agencies may enter facilities and inspect and copy records as part of an investigation. The county social service agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. The inquiry is not limited to the written records of the facility, but may include every other available source of information.

(g) When necessary in order to protect a vulnerable adult from serious harm, the county social service agency shall immediately intervene on behalf of that adult to help the family, vulnerable adult, or other interested person by seeking any of the following:

(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(2) the appointment of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;

(3) replacement of a guardian or conservator suspected of maltreatment and appointment of a suitable person as guardian or conservator, pursuant to sections 524.5-101 to 524.5-502; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 524.5-502 and chapter 563.

In proceedings under sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or organization to provide ongoing guardianship services. If the county presents evidence to the court exercising probate jurisdiction that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the person subject to guardianship or conservatorship, even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.