SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 2669

(SENATE AUTHORS: WIKLUND and Mann)

DATE	D-PG	OFFICIAL STATUS
03/17/2025	869	Introduction and first reading Referred to Health and Human Services
04/22/2025	3144a	Comm report: To pass as amended and re-refer to Taxes
04/23/2025		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to state government; establishing budget provisions for the Departments of Human Services, Health, and Children, Youth, and Families; modifying provisions relating to health, health licensing boards, health and education facilities, pharmacy benefits, health care finance, behavioral health, children's mental health terminology, assertive community treatment and intensive residential treatment services, background studies, Department of Human Services program integrity, human services licensing, economic supports, child protection and welfare, early care and learning, and children and families licensing; making conforming changes for the statutory establishment of the Department of Children, Youth, and Families; making forecast adjustments; requiring reports; establishing criminal penalties; appropriating money; amending Minnesota Statutes 2024, sections 3.732, subdivision 1; 3.922, subdivision 1; 10A.01, subdivision 35; 13.41, subdivision 1; 13.46, subdivisions 3, 4, 9, 10; 13.598, subdivision 10; 14.03, subdivision 3; 62A.673, subdivision 2; 62D.21; 62D.211; 62E.23, subdivision 1; 62J.461, subdivisions 3, 4, 5; 62J.51, subdivision 19a; 62J.581; 62J.84, subdivisions 2, 3, 6, 10, 11, 12, 13, 14, 15; 62K.10, subdivisions 2, 5, 6; 62M.17, subdivision 2; 62Q.522, subdivision 1; 62Q.527, subdivisions 1, 2, 3; 103I.005, subdivision 17b; 103I.101, subdivisions 2, 5, 6, by adding a subdivision; 103I.208, subdivisions 1, 1a, 2; 103I.235, subdivision 1; 103I.525, subdivisions 2, 6, 8; 103I.531, subdivisions 2, 6, 8; 103I.535, subdivisions 2, 6, 8; 103I.541, subdivisions 2b, 2c, 4; 103I.545, subdivisions 1, 2; 103I.601, subdivisions 2, 4; 116L.881; 121A.61, subdivision 3; 125A.15; 125A.744, subdivision 2; 127A.11; 127A.70, subdivision 2; 128C.02, subdivision 5; 136A.25; 136A.26; 136A.27; 136A.28; 136A.29, subdivisions 1, 3, 6, 9, 10, 14, 19, 20, 21, 22, by adding a subdivision; 136A.32, subdivisions 1, 4, by adding a subdivision; 136A.33; 136A.34, subdivisions 3, 4; 136A.36; 136A.38; 136A.41; 136A.42; 136F.67, subdivision 1; 138.912, subdivisions 1, 2, 3, 4, 6; 142A.03, subdivision 2, by adding a subdivision; 142A.607, subdivision 14; 142A.609, subdivision 21; 142A.76, subdivisions 2, 3; 142B.01, subdivision 15; 142B.05, subdivision 3; 142B.10, subdivision 14; 142B.16, subdivision 2; 142B.171, subdivision 2; 142B.30, subdivision 1; 142B.41, subdivision 9, by adding a subdivision; 142B.47; 142B.51, subdivision 2; 142B.65, subdivisions 8, 9; 142B.66, subdivision 3; 142B.70, subdivisions 7, 8; 142B.80; 142C.06, by adding a subdivision; 142C.11, subdivision 8; 142C.12, subdivisions 1, 6; 142D.31, subdivision 2; 142E.03, subdivision 3; 142E.11, subdivisions 1, 2; 142E.13, subdivision 2; 142E.15, subdivision 1; 142E.16, subdivisions 3, 7; 142E.51, subdivisions 5, 6; 142G.02, subdivision 56; 142G.27, subdivision 4; 142G.42, subdivision 3; 144.061; 144.0758, subdivision 3; 144.1205, subdivisions 2, 4, 8,

9, 10; 144.121, subdivisions 1a, 2, 5, by adding subdivisions; 144.1215, by adding a subdivision; 144.1222, subdivision 1a; 144.125, subdivision 2; 144.225, subdivision 2a; 144.3831, subdivision 1; 144.50, by adding a subdivision; 144.55, subdivision 1a; 144.554; 144.555, subdivisions 1a, 1b; 144.562, subdivisions 2, 3; 144.563; 144.608, subdivision 2; 144.651, subdivision 2; 144.966, subdivision 2; 144.99, subdivision 1; 144A.43, subdivision 15; 144E.123, subdivision 3; 144E.35; 144G.08, subdivision 45; 144G.45, subdivision 6; 145.8811; 145.895; 145.901, subdivisions 1, 2, 4; 145.9255, subdivision 1; 145.9265; 145.987, subdivisions 1, 2; 147.01, subdivision 7; 147.037, by adding a subdivision; 147A.02; 147D.03, subdivision 1; 148.108, subdivision 1, by adding subdivisions; 148.191, subdivision 2; 148.241; 148.512, subdivision 17a; 148.5192, subdivision 3; 148.5194, subdivision 3b; 148.56, subdivision 1; 148.6401; 148.6402, subdivisions 1, 7, 8, 13, 14, 16, 16a, 19, 20, 23, 25, by adding subdivisions; 148.6403; 148.6404; 148.6405; 148.6408, subdivision 2, by adding a subdivision; 148.6410, subdivision 2, by adding a subdivision; 148.6412, subdivisions 2, 3; 148.6415; 148.6418; 148.6420, subdivision 1; 148.6423, subdivisions 1, 2, by adding a subdivision; 148.6425, subdivision 2, by adding subdivisions; 148.6428; 148.6432, subdivisions 1, 2, 3, 4, by adding a subdivision; 148.6435; 148.6438; 148.6443, subdivisions 3, 4, 5, 6, 7, 8; 148.6445, by adding subdivisions; 148.6448, subdivisions 1, 2, 4, 6; 148.6449, subdivisions 1, 2, 7; 148B.53, subdivision 3; 148E.180, subdivisions 1, 5, 7, by adding subdivisions; 148F.11, subdivision 1; 149A.02, by adding a subdivision; 150A.105, by adding a subdivision; 151.01, subdivisions 15, 23; 151.065, subdivisions 1, 3, 6; 151.101; 151.741, subdivision 5; 152.12, subdivision 1; 153B.85, subdivisions 1, 3; 156.015, by adding subdivisions; 157.16, subdivisions 2, 2a, 3, 3a, by adding a subdivision; 174.285, subdivision 4; 214.104; 216C.266, subdivisions 2, 3; 241.021, subdivision 2; 242.09; 242.21; 242.32, subdivision 1; 245.095, subdivision 5, by adding a subdivision; 245.462, subdivisions 4, 20; 245.4661, subdivisions 2, 6, 7, 9; 245.4662, subdivision 1; 245.467, subdivision 4; 245.4682, subdivision 3; 245.469; 245.4711, subdivisions 1, 4; 245.4712, subdivisions 1, 3; 245.4835, subdivision 2; 245.4863; 245.487, subdivision 2; 245.4871, subdivisions 3, 4, 5, 6, 13, 15, 17, 19, 21, 22, 28, 29, 31, 32, 34, by adding a subdivision; 245.4873, subdivision 2; 245.4874, subdivision 1; 245.4875, subdivision 5; 245.4876, subdivisions 4, 5; 245.4877; 245.488, subdivisions 1, 3; 245.4881, subdivisions 1, 3, 4; 245.4882, subdivisions 1, 5; 245.4884; 245.4885, subdivision 1; 245.4889, subdivision 1; 245.4901, subdivision 3; 245.4905; 245.4906, subdivision 2; 245.4907, subdivisions 2, 3; 245.491, subdivision 2; 245.492, subdivision 3; 245.50, subdivision 3, by adding a subdivision; 245.697, subdivisions 1, 2a; 245.814, subdivisions 1, 2, 3, 4; 245.826; 245.91, subdivisions 2, 4; 245.92; 245.94, subdivision 1; 245.975, subdivision 1; 245A.03, subdivision 2; 245A.04, subdivisions 1, 7; 245A.05; 245A.07, subdivision 2; 245A.16, subdivision 1; 245A.18, subdivision 1; 245A.242, subdivision 2; 245A.26, subdivisions 1, 2; 245C.02, subdivisions 7, 12, 13, by adding a subdivision; 245C.031, subdivision 9; 245C.033, subdivision 2; 245C.05, subdivision 7, by adding a subdivision; 245C.07; 245C.08, subdivision 3; 245C.13, subdivision 2; 245C.14, by adding subdivisions; 245C.15, subdivision 4a; 245C.22, subdivision 5; 245D.02, subdivision 4a; 245I.05, subdivisions 3, 5; 245I.06, subdivision 3; 245I.11, subdivision 5; 245I.12, subdivision 5; 245I.23, subdivision 7; 246C.12, subdivision 4; 252.27, subdivision 1; 254B.04, subdivision 1a; 254B.05, subdivision 1a; 254B.06, by adding a subdivision; 256.01, by adding a subdivision; 256.478, subdivision 2; 256.88; 256.89; 256.90; 256.91; 256.92; 256.9657, by adding a subdivision; 256.969, subdivision 2b; 256.98, subdivision 1; 256.983, subdivision 4; 256B.02, subdivision 11; 256B.0371, subdivision 3; 256B.04, subdivision 21; 256B.051, subdivision 3; 256B.055, subdivision 12; 256B.0615, subdivisions 1, 3; 256B.0616, subdivisions 1, 4, 5; 256B.0622, subdivisions 1, 3a, 7a, 8, 11, 12; 256B.0625, subdivisions 2, 3b, 13, 13c, 13d, 13e, 17a, 20, 25c, 30, 54, by adding subdivisions; 256B.064, subdivision 1a; 256B.0659, subdivision 21; 256B.0757, subdivisions 2, 5, by adding a subdivision; 256B.0943, subdivisions 1, 3, 9, 12, 13; 256B.0945, subdivision 1; 256B.0946, subdivision 6; 256B.0947,

subdivision 3a; 256B.12; 256B.1973, by adding a subdivision; 256B.69, subdivisions 6d, 23, by adding a subdivision; 256B.76, subdivisions 1, 6, by adding a subdivision; 256B.761; 256B.766; 256B.77, subdivision 7a; 256B.82; 256B.85, subdivision 12; 256D.44, subdivision 5; 256G.01, subdivisions 1, 3; 256G.03, subdivision 2; 256G.04, subdivision 2; 256G.09, subdivisions 2, 3, 4, 5; 256G.10; 256G.11; 256G.12, subdivision 1; 256L.03, subdivision 5; 256R.01, by adding a subdivision; 260.65; 260.66, subdivision 1; 260.691, subdivision 1; 260.692; 260.762, subdivision 2a; 260.810, subdivisions 1, 2; 260.821, subdivision 2; 260B.157, subdivision 3; 260B.171, subdivision 4; 260C.001, subdivision 2; 260C.007, subdivisions 16, 19, 26d, 27b; 260C.150, subdivision 3; 260C.157, subdivision 3; 260C.201, subdivisions 1, 2; 260C.202, subdivision 2; 260C.204; 260C.212, subdivisions 1, 1a; 260C.221, subdivision 2; 260C.223, subdivisions 1, 2; 260C.301, subdivision 4; 260C.329, subdivision 8; 260C.452, subdivision 4; 260D.01; 260D.02, subdivisions 5, 9; 260D.03, subdivision 1; 260D.04; 260D.06, subdivision 2; 260D.07; 260E.03, subdivisions 6, 15; 260E.09; 260E.11, subdivisions 1, 3; 260E.20, subdivision 1; 260E.24, subdivisions 1, 2; 260E.30, subdivision 4; 260E.33, subdivision 6; 261.232; 270B.14, subdivision 1, by adding a subdivision; 295.50, subdivision 9b; 295.52, subdivisions 1, 1a, 2, 3, 4; 299C.76, subdivision 1; 299F.011, subdivision 4a; 326.72, subdivision 1; 326.75, subdivisions 3, 3a; 327.15, subdivisions 3, 4, by adding a subdivision; 354B.20, subdivision 7; 402A.10, subdivisions 1a, 2, 4c; 402A.12; 402A.16, subdivisions 1, 2, 3, 4; 402A.18, subdivisions 2, 3, by adding a subdivision; 402A.35, subdivisions 1, 4, 5; 462A.2095, subdivision 6; 466.131; 518.165, subdivision 5; 524.5-106; 524.5-118, subdivision 2; 595.02, subdivision 2; 626.5533; Laws 2021, First Special Session chapter 7, article 2, section 81; Laws 2023, chapter 70, article 7, section 34; article 20, section 2, subdivisions 7, 30; Laws 2024, chapter 127, article 67, sections 4; 6; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 62V; 142B; 142F; 144; 144E; 145; 148; 153; 245; 256B; 260E; 295; 306; 307; 609; proposing coding for new law as Minnesota Statutes, chapter 148G; repealing Minnesota Statutes 2024, sections 62E.21; 62E.22; 62E.23; 62E.24; 62E.25; 62J.824; 62K.10, subdivision 3; 103I.550; 136A.29, subdivision 4; 138.912, subdivision 7; 142A.15; 142E.50, subdivisions 2, 12; 148.108, subdivisions 2, 3, 4; 148.6402, subdivision 22a; 148.6420, subdivisions 2, 3, 4; 148.6423, subdivisions 4, 5, 7, 8, 9; 148.6425, subdivision 3; 148.6430; 148.6445, subdivisions 5, 6, 8; 156.015, subdivision 1; 245A.02, subdivision 6d; 245A.11, subdivision 8; 256B.0622, subdivision 4; 256B.0625, subdivision 38; 256G.02, subdivisions 3, 5; 261.003; Minnesota Rules, parts 2500.1150; 2500.2030; 4695.2900; 6800.5100, subpart 5; 6800.5400, subparts 5, 6; 6900.0250, subparts 1, 2; 9100.0400, subparts 1, 3; 9100.0500; 9100.0600.

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

ARTICLE 1

DEPARTMENT OF HEALTH FINANCE

Section 1. Minnesota Statutes 2024, section 62D.21, is amended to read:

62D.21 FEES.

Every health maintenance organization subject to sections 62D.01 to 62D.30 shall pay to the commissioner of health the following fees ~~as prescribed by the commissioner of health pursuant to section 144.122 for the following~~:

(1) filing an application for a certificate of authority: $10,000;

(2) filing an amendment to a certificate of authority: $125;

(3) filing each annual report: $400; ~~and~~

~~(4) other filings, as specified by rule.~~

(4) filing each quarterly report: $200; and

(5) filing annual plan review documents, amendments to plan documents, and quality plans: $125.

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

Sec. 2. Minnesota Statutes 2024, section 62D.211, is amended to read:

62D.211 RENEWAL FEE.

Each health maintenance organization subject to sections 62D.01 to 62D.30 shall submit to the commissioner of health each year before June 15 a certificate of authority renewal fee in the amount of ~~$10,000~~ $30,000 each plus ~~20~~ 88 cents per person enrolled in the health maintenance organization on December 31 of the preceding year. ~~The commissioner may adjust the renewal fee in rule under the provisions of chapter 14.~~

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

Sec. 3. **[62J.8241] FACILITY FEES PROHIBITED.**

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

(b) "Facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

(c) "Health care provider" has the meaning given in section 145B.02. Health care provider does not include any critical access hospital.

(d) "Provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144 and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition

does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

Subd. 2. **Provider-based clinic prohibition.** Health care providers are prohibited from charging, billing, or collecting a facility fee for nonemergency services provided at a provider-based clinic, including services provided by telehealth as defined in section 62A.673, subdivision 2, paragraph (h).

Subd. 3. **Service-specific prohibition.** (a) Regardless of where the services are provided, except for at emergency departments located on a hospital campus, health care providers are prohibited from charging, billing, or collecting a facility fee for outpatient evaluation and management services.

(b) Notwithstanding paragraph (a), a health care provider may charge, bill, or collect a facility fee for observation stays on a hospital campus and for outpatient services that use a current procedural terminology (CPT) evaluation and management code or CPT assessment and management code when billed for wound care, orthopedics, anticoagulation, oncology, obstetrics, and solid organ transplant.

Subd. 4. **Reporting.** (a) By January 15, 2027, and each year thereafter, hospitals licensed under chapter 144 and health systems operating one or more hospitals licensed under chapter 144 must submit a report to the commissioner of health identifying facility fees charged, billed, and collected during the preceding calendar year. The commissioner must publish the information reported on a publicly accessible website. The report shall be in the format prescribed by the commissioner of health.

(b) The report under this subdivision must include the following information for each facility owned or operated by the hospital or health system providing services for which a facility fee is charged, billed, or collected:

(1) the name and full address of each facility;

(2) the number of patient visits at each facility; and

(3) the number, total amount, and range of allowable facility fees paid at each facility by Medicare, medical assistance, MinnesotaCare, and private insurance.

(c) The report under this subdivision must include the following information for the entire hospital or health system:

(1) the total amount charged and billed for facility fees;

(2) the total amount collected from facility fees;

(3) the top ten procedures or services provided by the hospital or health system that generated the greatest amount of facility fee gross revenue, the volume of each of these ten procedures or services and the gross and net revenue totals for each procedure or service, and the total net amount of revenue received by the hospital or health system derived from facility fees;

(4) the top ten procedures or services, based on patient volume, provided by the hospital or health system for which facility fees are charged, billed, or collected, based on patient volume, including the gross and net revenue totals received for each such procedure or service; and

(5) any other information related to facility fees that the commissioner of health may require.

Subd. 5. **Enforcement.** (a) A violation of this section is an unlawful business practice for purposes of section 8.31. The attorney general may enforce this section pursuant to section 8.31.

(b) In addition to penalties provided in paragraph (a), the commissioner of health may, pursuant to the procedures in sections 144.99 and 144.991, impose an administrative penalty on a health care provider for failure to comply with subdivision 4. The penalty must not exceed $1,000 per occurrence.

(c) The commissioner of health or the commissioner's designee may audit any health care provider for compliance with the requirements of this section. A health care provider must make available, upon written request of the commissioner or the commissioner's designee, copies of any books, documents, records, or data that are necessary for the purposes of completing the audit for four years after the furnishing of any services for which a facility fee was charged, billed, or collected.

Sec. 4. Minnesota Statutes 2024, section 103I.101, subdivision 6, is amended to read:

Subd. 6. **Fees for variances.** The commissioner shall charge a nonrefundable application fee of ~~$275~~ $325 to cover the ~~administrative~~ cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

Sec. 5. Minnesota Statutes 2024, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property owner is:

(1) for construction of a water supply well, ~~$275~~ $325, which includes the state core function fee;

(2) for a well sealing, ~~$75~~ $125 for each well or temporary boring, which includes the state core function fee, except that: (i) a single notification and fee of ~~$75~~ $125 is required for all temporary borings on a single property and sealed within 72 hours of start of construction; and (ii) temporary borings less than 25 feet in depth are exempt from the notification and fee requirements in this chapter;

(3) for construction of a dewatering well, ~~$275~~ $330, which includes the state core function fee, for each dewatering well, except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of ~~$1,375~~ $1,620 for the dewatering wells recorded on the notification; and

(4) for construction of an environmental well, ~~$275~~ $330, which includes the state core function fee, ~~except that a single fee of $275 is required for all environmental wells recorded on the notification that are located on a single property, and except that no fee is required for construction of a temporary boring~~ for each environmental well, except an environmental well site project comprising five or more environmental wells shall be assessed a single fee of $1,620 for the environmental wells recorded on the notification.

Sec. 6. Minnesota Statutes 2024, section 103I.208, subdivision 1a, is amended to read:

Subd. 1a. **State core function fee.** The state core function fee to be collected by the state and delegated community health boards and used to support state core functions is:

(1) for a new well, ~~$20~~ $40; and

(2) for a well sealing, ~~$5~~ $15.

Sec. 7. Minnesota Statutes 2024, section 103I.208, subdivision 2, is amended to read:

Subd. 2. **Permit fee.** (a) The permit fee to be paid by a property owner is:

(1) for a water supply well that is not in use under a maintenance permit, ~~$175~~ $225 annually;

(2) for an environmental well that is unsealed under a maintenance permit, ~~$175 annually except~~ no fee is required for an environmental well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, a watershed district, an organization formed for the joint exercise of

powers under section 471.59, a community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;

(3) for environmental wells on an environmental well site that are unsealed under a maintenance permit~~,~~:

~~$175~~ (i) $225 annually for one to ten environmental wells per site ~~regardless of the number of environmental wells located on site~~;

(ii) $325 annually for 11 to 20 environmental wells per site; and

(iii) $425 annually for 21 or more environmental wells per site;

(4) for a groundwater thermal exchange device, in addition to the notification fee for water supply wells, ~~$275~~ $350 for systems using 20 gallons per minute or less and $590 for systems using over 20 gallons per minute, which includes the state core function fee;

(5) for a bored geothermal heat exchanger with less than ten tons of heating/cooling capacity, ~~$275~~ $350;

(6) for a bored geothermal heat exchanger with ten to 50 tons of heating/cooling capacity, ~~$515~~ $590;

(7) for a bored geothermal heat exchanger with greater than 50 tons of heating/cooling capacity, ~~$740~~ $815;

(8) for a dewatering well that is unsealed under a maintenance permit, ~~$175~~ $330 annually for each dewatering well, except a dewatering project comprising ~~more than~~ five or more dewatering wells shall be issued a single permit for ~~$875~~ $1,620 annually for dewatering wells recorded on the permit;

(9) for an elevator boring, ~~$275~~ $325 for each boring; and

(10) for a submerged closed loop heat exchanger system, in addition to the notification fee for water supply wells, $3,250, which includes the state core function fee.

(b) For purposes of this subdivision, an environmental well site includes all of the environmental wells on a single property. A single property is considered one tax parcel or multiple contiguous parcels with the same owner.

Sec. 8. Minnesota Statutes 2024, section 103I.235, subdivision 1, is amended to read:

Subdivision 1. **Disclosure of wells to buyer.** (a) Before signing an agreement to sell or transfer real property, the seller must disclose in writing to the buyer information about the status and location of all known wells on the property, by delivering to the buyer either a

statement by the seller that the seller does not know of any wells on the property, or a disclosure statement indicating the legal description and county, and a map drawn from available information showing the location of each well to the extent practicable. In the disclosure statement, the seller must indicate, for each well, whether the well is in use, not in use, or sealed.

(b) At the time of closing of the sale, the disclosure statement information, name and mailing address of the buyer, and the quartile, section, township, and range in which each well is located must be provided on a well disclosure certificate signed by the seller or a person authorized to act on behalf of the seller.

(c) A well disclosure certificate need not be provided if the seller does not know of any wells on the property and the deed or other instrument of conveyance contains the statement: "The Seller certifies that the Seller does not know of any wells on the described real property."

(d) If a deed is given pursuant to a contract for deed, the well disclosure certificate required by this subdivision shall be signed by the buyer or a person authorized to act on behalf of the buyer. If the buyer knows of no wells on the property, a well disclosure certificate is not required if the following statement appears on the deed followed by the signature of the grantee or, if there is more than one grantee, the signature of at least one of the grantees: "The Grantee certifies that the Grantee does not know of any wells on the described real property." The statement and signature of the grantee may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement by the grantee is not required for the deed to be recordable.

(e) This subdivision does not apply to the sale, exchange, or transfer of real property:

(1) that consists solely of a sale or transfer of severed mineral interests; or

(2) that consists of an individual condominium unit as described in chapters 515 and 515B.

(f) For an area owned in common under chapter 515 or 515B the association or other responsible person must report to the commissioner by July 1, 1992, the location and status of all wells in the common area. The association or other responsible person must notify the commissioner within 30 days of any change in the reported status of wells.

(g) If the seller fails to provide a required well disclosure certificate, the buyer, or a person authorized to act on behalf of the buyer, may sign a well disclosure certificate based

on the information provided on the disclosure statement required by this section or based on other available information.

(h) A county recorder or registrar of titles may not record a deed or other instrument of conveyance dated after October 31, 1990, for which a certificate of value is required under section 272.115, or any deed or other instrument of conveyance dated after October 31, 1990, from a governmental body exempt from the payment of state deed tax, unless the deed or other instrument of conveyance contains the statement made in accordance with paragraph (c) or (d) or is accompanied by the well disclosure certificate containing all the information required by paragraph (b) or (d). The county recorder or registrar of titles must not accept a certificate unless it contains all the required information. The county recorder or registrar of titles shall note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure certificate was received. The notation must include the statement "No wells on property" if the disclosure certificate states there are no wells on the property. The well disclosure certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~$50~~ $54 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~$42.50~~ $46.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

(i) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached

sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

(j) The commissioner in consultation with county recorders shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

(k) Failure to comply with a requirement of this subdivision does not impair:

(1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or

(2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this subdivision.

Sec. 9. Minnesota Statutes 2024, section 103I.525, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of a well contractor is ~~$75~~ $100. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a well contractor is ~~$75~~ $100. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 10. Minnesota Statutes 2024, section 103I.525, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for a well contractor's license is ~~$250~~ $300.

Sec. 11. Minnesota Statutes 2024, section 103I.525, subdivision 8, is amended to read:

Subd. 8. **Renewal.** (a) A licensee must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee for a well contractor's license is ~~$250~~ $300.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well and boring construction reports, well and boring sealing reports, reports of elevator borings, water sample analysis reports, well and boring permits, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 12. Minnesota Statutes 2024, section 103I.531, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of a limited well/boring contractor is ~~$75~~ $100. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of a limited well/boring contractor is ~~$75~~ $100. The commissioner may not renew a certification until the renewal fee is paid.

(c) The fee for three or more limited well/boring contractor certifications is ~~$225~~ $275.

(d) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 13. Minnesota Statutes 2024, section 103I.531, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for a limited well/boring contractor's license is ~~$75~~ $100. The fee for three or more limited well/boring contractor licenses is ~~$225~~ $275.

Sec. 14. Minnesota Statutes 2024, section 103I.531, subdivision 8, is amended to read:

Subd. 8. **Renewal.** (a) A person must file an application and a renewal application fee to renew the limited well/boring contractor's license by the date stated in the license.

(b) The renewal application fee for a limited well/boring contractor's license is ~~$75~~ $100.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well and boring construction reports, well and boring sealing reports, well and boring permits, water quality sample reports, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 15. Minnesota Statutes 2024, section 103I.535, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** (a) The application fee for certification as a representative of an elevator boring contractor is ~~$75~~ $100. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of an elevator boring contractor is ~~$75~~ $100. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 16. Minnesota Statutes 2024, section 103I.535, subdivision 6, is amended to read:

Subd. 6. **License fee.** The fee for an elevator boring contractor's license is ~~$75~~ $100.

Sec. 17. Minnesota Statutes 2024, section 103I.535, subdivision 8, is amended to read:

Subd. 8. **Renewal.** (a) A person must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee for an elevator boring contractor's license is ~~$75~~ $100.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of renewal, the commissioner must have on file all reports and permits for elevator boring work conducted by the licensee since the last license renewal.

Sec. 18. Minnesota Statutes 2024, section 103I.541, subdivision 2b, is amended to read:

Subd. 2b. **Issuance of license.** If a person employs a certified representative, submits the bond under subdivision 3, and pays the license fee of ~~$75~~ $100 for an environmental well contractor license, the commissioner shall issue an environmental well contractor license to the applicant. The fee for an individual registration is ~~$75~~ $100. The commissioner may not act on an application until the application fee is paid.

Sec. 19. Minnesota Statutes 2024, section 103I.541, subdivision 2c, is amended to read:

Subd. 2c. **Certification fee.** (a) The application fee for certification as a representative of an environmental well contractor is ~~$75~~ $100. The commissioner may not act on an application until the application fee is paid.

(b) The renewal fee for certification as a representative of an environmental well contractor is ~~$75~~ $100. The commissioner may not renew a certification until the renewal fee is paid.

(c) A certified representative must file an application and a renewal application fee to renew the certification by the date stated in the certification. The renewal application must include information that the certified representative has met continuing education requirements established by the commissioner by rule.

Sec. 20. Minnesota Statutes 2024, section 103I.541, subdivision 4, is amended to read:

Subd. 4. **License renewal.** (a) A person must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee for an environmental well contractor's license is ~~$75~~ $100.

(c) The renewal application must include information that the certified representative of the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all well and boring construction reports, well and boring sealing reports, well permits, and notifications for work conducted by the licensed person since the last license renewal.

Sec. 21. Minnesota Statutes 2024, section 103I.545, subdivision 1, is amended to read:

Subdivision 1. **Drilling machine.** (a) A person may not use a drilling machine such as a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license under this chapter unless the drilling machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a ~~$75~~ $125 registration fee.

(c) A registration is valid for one year.

Sec. 22. Minnesota Statutes 2024, section 103I.545, subdivision 2, is amended to read:

Subd. 2. **Hoist.** (a) A person may not use a machine such as a hoist for an activity requiring a license under this chapter to repair wells or borings, seal wells or borings, or install pumps unless the machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a ~~$75~~ $125 registration fee.

(c) A registration is valid for one year.

Sec. 23. Minnesota Statutes 2024, section 103I.601, subdivision 2, is amended to read:

Subd. 2. **License required to make borings.** (a) Except as provided in paragraph (d), a person must not make an exploratory boring without an explorer's license. The fee for an explorer's license is ~~$75~~ $100. The explorer's license is valid until the date prescribed in the license by the commissioner.

(b) A person must file an application and renewal application fee to renew the explorer's license by the date stated in the license. The renewal application fee is ~~$75~~ $100.

(c) If the licensee submits an application fee after the required renewal date, the licensee:

(1) must include a late fee of $75; and

(2) may not conduct activities authorized by an explorer's license until the renewal application, renewal application fee, late fee, and sealing reports required in subdivision 9 are submitted.

(d) An explorer must designate a responsible individual to supervise and oversee the making of exploratory borings.

(1) Before an individual supervises or oversees an exploratory boring, the individual must file an application and application fee of ~~$75~~ $100 to qualify as a certified responsible individual.

(2) The individual must take and pass an examination relating to construction, location, and sealing of exploratory borings. A professional engineer or geoscientist licensed under sections 326.02 to 326.15 or a professional geologist certified by the American Institute of Professional Geologists is not required to take the examination required in this subdivision, but must be certified as a responsible individual to supervise an exploratory boring.

(3) The individual must file an application and a renewal fee of ~~$75~~ $100 to renew the responsible individual's certification by the date stated in the certification. If the certified

responsible individual submits an application fee after the renewal date, the certified responsible individual must include a late fee of $75 and may not supervise or oversee exploratory borings until the renewal application, application fee, and late fee are submitted.

Sec. 24. Minnesota Statutes 2024, section 103I.601, subdivision 4, is amended to read:

Subd. 4. **Notification and map of borings.** (a) By ten days before beginning exploratory boring, an explorer must submit to the commissioner of health a notification of the proposed boring map and a fee of ~~$275~~ $325 for each boring constructed.

(b) By ten days before beginning exploratory boring, an explorer must submit to the commissioners of health and natural resources a county road map on a single sheet of paper that is 8-1/2 by 11 inches in size and having a scale of one-half inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute series topographic map (1:24,000 scale), as prepared by the United States Geological Survey, showing the location of each proposed exploratory boring to the nearest estimated 40 acre parcel. Exploratory boring that is proposed on the map may not be commenced later than 180 days after submission of the map, unless a new map is submitted.

Sec. 25. **[144.063] DEMENTIA SERVICES PROGRAM ESTABLISHED.**

The commissioner of health shall establish the dementia services program to:

(1) facilitate the coordination and support of:

(i) state-funded policies and programs that relate to Alzheimer's disease and related forms of dementia;

(ii) outreach programs and services between state agencies, local public health departments, Tribal Nations, educational institutions, and community groups for the purpose of fostering public awareness and education regarding Alzheimer's disease and related forms of dementia; and

(iii) services and activities between groups that are interested in dementia research, programs, and services, including area agencies on aging, service providers, advocacy groups, legal services, emergency personnel, law enforcement, local public health departments, Tribal Nations, and state colleges and universities;

(2) facilitate the coordination, review, publication, and implementation of and updates to the Minnesota Dementia Strategic Plan;

(3) collect and analyze data related to the impact of Alzheimer's disease and related forms of dementia in Minnesota; and

(4) incorporate early detection and risk reduction strategies into existing department-led public health programs.

Sec. 26. Minnesota Statutes 2024, section 144.1205, subdivision 2, is amended to read:

Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent to the annual fee upon issuance of the initial license.

(b) A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	LICENSE FEE
Academic broad scope - type A, B, or C	~~$25,896~~ $34,500
Academic broad scope - type A, B, or C (4-8 locations)	~~$31,075~~ $41,400
Academic broad scope - type A, B, or C (9 or more locations)	~~$36,254~~ $48,300
Medical broad scope - type A	~~$25,896~~ $34,500
Medical broad scope - type A (4-8 locations)	~~$31,075~~ $41,400
Medical broad scope - type A (9 or more locations)	~~$36,254~~ $48,300
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	~~$4,784~~ $6,600
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	~~$5,740~~ $7,900
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	~~$6,697~~ $9,200
Teletherapy	~~$11,648~~ $15,500
Gamma knife	~~$11,648~~ $15,500
Veterinary medicine	~~$2,600~~ $3,500
In vitro testing lab	~~$2,600~~ $3,500
Nuclear pharmacy	~~$11,440~~ $15,300

	~~$13,728~~
Nuclear pharmacy (5 or more locations)	$18,300
	~~$4,992~~
Radiopharmaceutical distribution (10 CFR 32.72)	$6,700
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~$11,440~~ $15,300
Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	~~$13,728~~ $18,300
	~~$4,992~~
Medical sealed sources - distribution (10 CFR 32.74)	$6,700
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~$11,440~~ $15,300
Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	~~$13,728~~ $18,300
	~~$4,888~~
Well logging - sealed sources	$6,600
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~$2,600~~ $3,800
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	~~$3,120~~ $4,500
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	~~$3,640~~ $5,200
	~~$1,976~~
X-ray fluorescent analyzer	$2,700
	~~$25,896~~
Manufacturing and distribution - type A broad scope	$34,500
Manufacturing and distribution - type A broad scope (4-8 locations)	~~$31,075~~ $41,400
Manufacturing and distribution - type A broad scope (9 or more locations)	~~$36,254~~ $48,300
	~~$22,880~~
Manufacturing and distribution - type B or C broad scope	$30,500
Manufacturing and distribution - type B or C broad scope (4-8 locations)	~~$27,456~~ $36,600
Manufacturing and distribution - type B or C broad scope (9 or more locations)	~~$32,032~~ $42,700
	~~$6,864~~
Manufacturing and distribution - other	$9,200
	~~$8,236~~
Manufacturing and distribution - other (4-8 locations)	$11,000
	~~$9,609~~
Manufacturing and distribution - other (9 or more locations)	$12,800
	~~$24,232~~
Nuclear laundry	$32,300
	~~$6,448~~
Decontamination services	$8,600

	~~$2,600~~
Leak test services only	$3,500
	~~$2,600~~
Instrument calibration service only	$3,500
	~~$6,448~~
Service, maintenance, installation, source changes, etc.	$8,600
	~~$7,800~~
Waste disposal service, prepackaged only	$10,400
	~~$10,816~~
Waste disposal	$14,400
	~~$2,288~~
Distribution - general licensed devices (sealed sources)	$3,100
	~~$1,456~~
Distribution - general licensed material (unsealed sources)	$2,000
	~~$12,792~~
Industrial radiography - fixed or temporary location	$17,200
Industrial radiography - fixed or temporary location (5 or more locations)	~~$16,629~~ $22,300
	~~$3,744~~
Irradiators, self-shielding	$5,000
	~~$6,968~~
Irradiators, other, less than 10,000 curies	$9,300
	~~$12,376~~
Research and development - type A, B, or C broad scope	$16,500
Research and development - type A, B, or C broad scope (4-8 locations)	~~$14,851~~ $19,800
Research and development - type A, B, or C broad scope (9 or more locations)	~~$17,326~~ $23,100
	~~$5,824~~
Research and development - other	$7,800
	~~$2,600~~
Storage - no operations	$3,500
	~~$759~~
Source material - shielding	$1,100
	~~$4,784~~
Special nuclear material plutonium - neutron source in device	$6,400
Pacemaker by-product and/or special nuclear material - medical (institution)	~~$4,784~~ $6,400
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~$6,864~~ $9,200
	~~$4,992~~
Accelerator-produced radioactive material	$6,700
	~~$500~~
Nonprofit educational institutions	$700

Sec. 27. Minnesota Statutes 2024, section 144.1205, subdivision 4, is amended to read:

Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a renewal application fee according to this subdivision.

TYPE	APPLICATION FEE
Academic broad scope - type A, B, or C	~~$6,808~~ $9,100
Medical broad scope - type A	~~$4,508~~ $6,000
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	~~$1,748~~ $2,350
Teletherapy	~~$6,348~~ $8,450
Gamma knife	~~$6,348~~ $8,450
Veterinary medicine	~~$1,104~~ $1,500
In vitro testing lab	~~$1,104~~ $1,500
Nuclear pharmacy	~~$5,612~~ $7,500
Radiopharmaceutical distribution (10 CFR 32.72)	~~$2,484~~ $3,350
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~$5,612~~ $7,500
Medical sealed sources - distribution (10 CFR 32.74)	~~$2,484~~ $3,350
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~$5,612~~ $7,500
Well logging - sealed sources	~~$1,840~~ $2,450
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~$1,104~~ $1,500
X-ray fluorescent analyzer	~~$671~~ $900
Manufacturing and distribution - type A, B, and C broad scope	~~$6,854~~ $9,150
Manufacturing and distribution - other	~~$2,668~~ $3,550
Nuclear laundry	~~$11,592~~ $15,450
Decontamination services	~~$3,036~~ $4,050

	~~$1,104~~
Leak test services only	$1,500
	~~$1,104~~
Instrument calibration service only	$1,500
	~~$3,036~~
Service, maintenance, installation, source changes, etc.	$4,050
	~~$2,576~~
Waste disposal service, prepackaged only	$3,450
	~~$1,748~~
Waste disposal	$2,350
	~~$1,012~~
Distribution - general licensed devices (sealed sources)	$1,350
	~~$598~~
Distribution - general licensed material (unsealed sources)	$800
	~~$3,036~~
Industrial radiography - fixed or temporary location	$4,050
	~~$1,656~~
Irradiators, self-shielding	$2,250
	~~$3,404~~
Irradiators, other, less than 10,000 curies	$4,550
	~~$5,704~~
Research and development - type A, B, or C broad scope	$7,600
	~~$2,760~~
Research and development - other	$3,700
	~~$1,104~~
Storage - no operations	$1,500
	~~$156~~
Source material - shielding	$250
	~~$1,380~~
Special nuclear material plutonium - neutron source in device	$1,850
Pacemaker by-product and/or special nuclear material - medical	~~$1,380~~
(institution)	$1,850
Pacemaker by-product and/or special nuclear material -	~~$2,668~~
manufacturing and distribution	$3,550
	~~$4,715~~
Accelerator-produced radioactive material	$6,300
	~~$345~~
Nonprofit educational institutions	$500

Sec. 28. Minnesota Statutes 2024, section 144.1205, subdivision 8, is amended to read:

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay

~~$2,400~~ $3,200. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Sec. 29. Minnesota Statutes 2024, section 144.1205, subdivision 9, is amended to read:

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$600~~ $800 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; or

(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

Sec. 30. Minnesota Statutes 2024, section 144.1205, subdivision 10, is amended to read:

Subd. 10. **Fees for general license registrations.** A person required to register generally licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual registration fee of ~~$450~~ $600.

Sec. 31. Minnesota Statutes 2024, section 144.121, subdivision 1a, is amended to read:

Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing radiation-producing equipment and other sources of ionizing radiation must pay an initial or annual renewal registration fee consisting of a base facility fee of ~~$100~~ $155 and an additional fee for each x-ray tube, as follows:

(1) medical or veterinary equipment	$ ~~100~~ 130
(2) dental x-ray equipment	$ ~~40~~ 60
(3) x-ray equipment not used on humans or animals	$ ~~100~~ 130
(4) devices with sources of ionizing radiation not used on humans or animals	$ ~~100~~ 130
(5) security screening system	$ ~~100~~ 160
(6) radiation therapy and accelerator x-ray equipment	$ 1,000
(7) industrial accelerator x-ray equipment	$ 300

~~(b) A facility with radiation therapy and accelerator equipment must pay an initial or annual registration fee of $500. A facility with an industrial accelerator must pay an initial or annual registration fee of $150.~~

~~(c)~~ (b) Electron microscopy equipment is exempt from the registration fee requirements of this section.

~~(d)~~ (c) For purposes of this section, a security screening system means ionizing radiation-producing equipment designed and used for security screening of humans who are in the custody of a correctional or detention facility, and used by the facility to image and identify contraband items concealed within or on all sides of a human body. For purposes of this section, a correctional or detention facility is a facility licensed under section 241.021 and operated by a state agency or political subdivision charged with detection, enforcement, or incarceration in respect to state criminal and traffic laws. The commissioner shall adopt rules to establish requirements for the use of security screening systems. Notwithstanding section 14.125, the authority to adopt these rules does not expire.

Sec. 32. Minnesota Statutes 2024, section 144.121, is amended by adding a subdivision to read:

Subd. 1e. **Fee for service provider of ionizing radiation-producing equipment.** A service provider of ionizing radiation-producing equipment and other sources of ionizing radiation must pay an initial or annual renewal fee of $115.

Sec. 33. Minnesota Statutes 2024, section 144.121, subdivision 2, is amended to read:

Subd. 2. **Inspections.** Periodic radiation safety inspections of the x-ray equipment and other sources of ionizing radiation shall be made by the commissioner of health. The frequency of safety inspections shall be prescribed by the commissioner ~~on the basis of~~ based on the ~~frequency of~~ radiation exposure risk to occupational and public health from use of ~~the~~ x-ray equipment and other source of ionizing radiation~~, provided that each source shall be inspected at least once every four years~~.

Sec. 34. Minnesota Statutes 2024, section 144.121, subdivision 5, is amended to read:

Subd. 5. **Examination for individual operating x-ray systems.** (a) An individual in a facility with x-ray systems for use on living humans that is registered under subdivision 1 may not operate, nor may the facility allow the individual to operate, x-ray systems unless the individual has passed a national or state examination.

(b) Individuals who may operate x-ray systems include:

(1) an individual who has passed the American Registry of Radiologic Technologists (ARRT) registry for radiography examination;

(2) an individual who has passed the American Chiropractic Registry of Radiologic Technologists (ACRRT) registry examination and is limited to radiography of spines and extremities;

(3) a registered limited scope x-ray operator and a registered bone densitometry equipment operator who passed the examination requirements in paragraphs (d) and (e) and practices according to subdivision 5a;

(4) an x-ray operator who has the original certificate or the original letter of passing the examination that was required before January 1, 2008, under Minnesota Statutes 2008, section 144.121, subdivision 5a, paragraph (b), clause (1);

(5) an individual who has passed the American Registry of Radiologic Technologists (ARRT) registry for radiation therapy examination according to subdivision 5e;

(6) a cardiovascular technologist according to subdivision 5c;

(7) a nuclear medicine technologist according to subdivision 5d;

(8) an individual who has passed the examination for a dental hygienist under section 150A.06 and only operates dental x-ray systems;

(9) an individual who has passed the examination for a dental therapist under section 150A.06 and only operates dental x-ray systems;

(10) an individual who has passed the examination for a dental assistant under section 150A.06 and only operates dental x-ray systems;

(11) an individual who has passed the examination under Minnesota Rules, part ~~3100.8500, subpart 3~~ 3100.1320, and only operates dental x-ray systems; and

(12) a qualified practitioner who is licensed by a health-related licensing board with active practice authority and is working within the practitioner's scope of practice.

(c) Except for individuals under clauses (3) and (4), an individual who is participating in a training or educational program in any of the occupations listed in paragraph (b) is exempt from the examination requirement within the scope and for the duration of the training or educational program.

(d) The Minnesota examination for limited scope x-ray operators must include:

(1) radiation protection, radiation physics and radiobiology, equipment operation and quality assurance, image acquisition and technical evaluation, and patient interactions and management; and

(2) at least one of the following regions of the human anatomy: chest, extremities, skull and sinus, spine, or podiatry. The examinations must include the anatomy of, and radiographic positions and projections for, the specific regions.

(e) The examination for bone densitometry equipment operators must include:

(1) osteoporosis, bone physiology, bone health and patient education, patient preparation, fundamental principals, biological effects of radiation, units of measurements, radiation protection in bone densitometry, fundamentals of x-ray production, quality control, measuring bone mineral testing, determining quality in bone mineral testing, file and database management; and

(2) dual x-ray absorptiometry scanning of the lumbar spine, proximal femur, and forearm. The examination must include the anatomy, scan acquisition, and scan analysis for these three procedures.

(f) A limited scope x-ray operator, and a bone densitometry equipment operator, who are required to take an examination under this subdivision must submit to the commissioner a registration application for the examination and a $25 processing fee. The processing fee shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 35. Minnesota Statutes 2024, section 144.121, is amended by adding a subdivision to read:

Subd. 10. **Service provider practice; service technician.** (a) A service technician is a service provider who performs one or more of the following, including but not limited to: assembly, installation, calibration, equipment performance evaluation, preventive maintenance, repair, replacement, or disabling of ionizing radiation-producing equipment and other sources of ionizing radiation. A service technician may not perform an equipment performance evaluation on computed tomography, medical cone beam computed tomography, and fluoroscopy equipment.

(b) In order to provide service technician services, a service provider must register with the commissioner as a service technician, meet the applicable requirements in Minnesota Rules, chapter 4732, and pay the fee in subdivision 1e.

Sec. 36. Minnesota Statutes 2024, section 144.121, is amended by adding a subdivision to read:

Subd. 11. **Service provider practice; vendor.** (a) A vendor is a service provider who performs one or more of the following services, including but not limited to: sales, leasing, lending, transferring, disposal, or demonstration of ionizing radiation-producing equipment and other sources of ionizing radiation.

(b) In order to provide vendor services, a service provider must register with the commissioner as a vendor, meet the applicable requirements in Minnesota Rules, chapter 4732, and pay the fee in subdivision 1e.

Sec. 37. Minnesota Statutes 2024, section 144.121, is amended by adding a subdivision to read:

Subd. 12. **Service provider practice; qualified medical physicist.** (a) A qualified medical physicist is a service provider who provides medical physics services and must be certified in diagnostic medical physics, diagnostic radiological physics, radiological physics, diagnostic imaging physics, or diagnostic radiology physics by the American Board of Radiology, the American Board of Medical Physics, or the Canadian College of Physicists in Medicine.

(b) In order to provide medical physics services a service provider must register with the commissioner as a qualified medical physicist, meet the applicable requirements in Minnesota Rules, chapter 4732, and pay the fee in subdivision 1e.

Sec. 38. Minnesota Statutes 2024, section 144.121, is amended by adding a subdivision to read:

Subd. 13. **Service provider practice; qualified expert.** (a) A qualified expert is a service provider who provides expert physics services, and must be certified in the appropriate fields or specialties in which physics services are provided by the American Board of Health Physics, the American Board of Medical Physics, the American Board of Radiology, the American Board of Science in Nuclear Medicine, or the Canadian College of Physicists in Medicine.

(b) In order to provide health physics services, a service provider must register with the commissioner as a qualified expert, meet the applicable requirements in Minnesota Rules, chapter 4732, and pay the fee in subdivision 1e.

Sec. 39. Minnesota Statutes 2024, section 144.121, is amended by adding a subdivision to read:

Subd. 14. **Service provider practice; physicist assistant.** (a) A physicist assistant is a service provider who provides expert physics or medical physics services under the supervision of a qualified expert or a qualified medical physicist and must be deemed competent by a qualified expert or a qualified medical physicist in the appropriate fields or specialties in which services are provided.

(b) In order to provide health physics or medical physics services under the supervision of a qualified expert or a qualified medical physicist, a physicist assistant must register with the commissioner as a physicist assistant, meet the applicable requirements in Minnesota Rules, chapter 4732, and pay the fee under subdivision 1e.

(c) Supervision as used in this subdivision refers to either personal or general supervision of a physicist assistant by a qualified expert or a qualified medical physicist according to Minnesota Rules, chapter 4732.

Sec. 40. Minnesota Statutes 2024, section 144.121, is amended by adding a subdivision to read:

Subd. 15. **Service provider compliance.** A service provider registered with the commissioner under Minnesota Rules, chapter 4732, must, upon renewal of registration, comply with the applicable requirements under this section and submit the fee under subdivision 1e.

Sec. 41. Minnesota Statutes 2024, section 144.1215, is amended by adding a subdivision to read:

Subd. 5. **Rulemaking authority.** The commissioner shall adopt rules to implement this section. Notwithstanding section 14.125, the authority to adopt these rules does not expire.

Sec. 42. Minnesota Statutes 2024, section 144.1222, subdivision 1a, is amended to read:

Subd. 1a. **Fees.** All plans and specifications for public pool and spa construction, installation, or alteration or requests for a variance that are submitted to the commissioner according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate fees. All public pool construction plans submitted for review after January 1, 2009, must be certified by a professional engineer registered in the state of Minnesota. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid before plan approval. For purposes of determining

fees, a project is defined as a proposal to construct or install a public pool, spa, special purpose pool, or wading pool and all associated water treatment equipment and drains, gutters, decks, water recreation features, spray pads, and those design and safety features that are within five feet of any pool or spa. Plans submitted less than 30 days prior to construction are subject to 50 percent of the original plan review fee. The commissioner shall charge the following fees for plan review and inspection of public pools and spas and for requests for variance from the public pool and spa rules:

(1) each pool, ~~$1,500~~ $1,600;

(2) each spa pool, ~~$800~~ $900;

(3) each slide, ~~$600~~ $650;

(4) projects valued at $250,000 or more, the greater of the sum of the fees in clauses (1), (2), and (3) or 0.5 percent of the documented estimated project cost to a maximum fee of $15,000;

(5) alterations to an existing pool without changing the size or configuration of the pool, ~~$600~~ $700;

(6) removal or replacement of pool disinfection equipment only, ~~$100~~ $200; and

(7) request for variance from the public pool and spa rules, ~~$500~~ $550.

Sec. 43. **[144.1223] REGISTERED SANITARIANS AND REGISTERED ENVIRONMENTAL HEALTH SPECIALIST APPLICATION FEES.**

(a) Fees to be submitted with initial or renewal applications are as follows:

(1) initial application fee, $55;

(2) biennial renewal application fee, $55; and

(3) penalty for late submission of renewal application, $20, if not renewed by designated renewal date.

(b) Additionally, a $5 technology fee must be paid with the initial registration or registration renewal.

Sec. 44. Minnesota Statutes 2024, section 144.125, subdivision 2, is amended to read:

Subd. 2. **Determination of tests to be administered.** (a) The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical

science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of analytical methods to detect the heritable or congenital disorder, the ability to treat or prevent medical conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

(b) The commissioner shall revise the list of tests to be administered for determining the presence of a heritable or congenital disorder to include metachromatic leukodystrophy (MLD).

Sec. 45. Minnesota Statutes 2024, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$9.72~~ $15.22 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

Sec. 46. Minnesota Statutes 2024, section 144.55, subdivision 1a, is amended to read:

Subd. 1a. **License fee.** The annual license fee for outpatient surgical centers is ~~$1,512~~ $1,966.

Sec. 47. Minnesota Statutes 2024, section 144.554, is amended to read:

144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND FEES.

For hospitals, nursing homes, assisted living facilities, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities, the commissioner shall collect a fee for the review and approval of architectural, mechanical, and electrical plans and specifications submitted before construction begins for each project relative to construction of new buildings, additions to existing buildings, or remodeling or alterations of existing buildings. All fees collected in this section shall be deposited in the state treasury and credited to the state government

special revenue fund. Fees must be paid at the time of submission of final plans for review and are not refundable. The fee is calculated as follows:

Construction project total estimated cost	Fee
$0 - $10,000	~~$30~~ $45
$10,001 - $50,000	~~$150~~ $225
$50,001 - $100,000	~~$300~~ $450
$100,001 - $150,000	~~$450~~ $675
$150,001 - $200,000	~~$600~~ $900
$200,001 - $250,000	~~$750~~ $1,125
$250,001 - $300,000	~~$900~~ $1,350
$300,001 - $350,000	~~$1,050~~ $1,575
$350,001 - $400,000	~~$1,200~~ $1,800
$400,001 - $450,000	~~$1,350~~ $2,025
$450,001 - $500,000	~~$1,500~~ $2,250
$500,001 - $550,000	~~$1,650~~ $2,475
$550,001 - $600,000	~~$1,800~~ $2,700
$600,001 - $650,000	~~$1,950~~ $2,925
$650,001 - $700,000	~~$2,100~~ $3,150
$700,001 - $750,000	~~$2,250~~ $3,375
$750,001 - $800,000	~~$2,400~~ $3,600
$800,001 - $850,000	~~$2,550~~ $3,825
$850,001 - $900,000	~~$2,700~~ $4,050
$900,001 - $950,000	~~$2,850~~ $4,275
$950,001 - $1,000,000	~~$3,000~~ $4,500
$1,000,001 - $1,050,000	~~$3,150~~ $4,725
$1,050,001 - $1,100,000	~~$3,300~~ $4,950
$1,100,001 - $1,150,000	~~$3,450~~ $5,175
$1,150,001 - $1,200,000	~~$3,600~~ $5,400
$1,200,001 - $1,250,000	~~$3,750~~ $5,625
$1,250,001 - $1,300,000	~~$3,900~~ $5,850
$1,300,001 - $1,350,000	~~$4,050~~ $6,075
$1,350,001 - $1,400,000	~~$4,200~~ $6,300
$1,400,001 - $1,450,000	~~$4,350~~ $6,525
$1,450,001 - $1,500,000	~~$4,500~~ $6,750
$1,500,001 ~~and over~~ - $2,000,000	~~$4,800~~ $7,200
$2,000,001 - $3,000,000	$7,650
$3,000,001 - $4,000,000	$8,100

$4,000,001 - $7,000,000	$8,550
$7,000,001 - $15,000,000	$9,000
$15,000,001 - $50,000,000	$9,450
$50,000,001 and over	$9,900

Sec. 48. Minnesota Statutes 2024, section 144.562, subdivision 2, is amended to read:

Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total number of days of swing bed use per year as provided in paragraph (c). Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law. A critical access hospital described in section 144.5621 is allowed an unlimited number of days of swing bed use per year.

(c) An eligible hospital is allowed a total of 3,000 days of swing bed use in calendar year 2020. Beginning in calendar year 2021, and for each subsequent calendar year until calendar year 2027, the total number of days of swing bed use per year is increased by 200 swing bed use days. Beginning in calendar year 2028, an eligible hospital is allowed a total of 4,500 days of swing bed use per year.

(d) Days of swing bed use for medical care that an eligible hospital has determined are charity care shall not count toward the applicable limit in paragraph (b) or (c). For purposes of this paragraph, "charity care" means care that an eligible hospital provided for free or at a discount to persons who cannot afford to pay and for which the eligible hospital did not expect payment.

(e) Days of swing bed use for care of a person who has been denied admission to every Medicare-certified skilled nursing facility within 25 miles of the eligible hospital shall not count toward the applicable limit in paragraphs (b) and (c). Eligible hospitals must maintain documentation that they have contacted each skilled nursing facility within 25 miles to determine if any skilled nursing facility beds are available and if the skilled nursing facilities are willing to admit the patient. Skilled nursing facilities that are contacted must admit the patient or deny admission within 24 hours of being contacted by the eligible hospital. Failure to respond within 24 hours is deemed a denial of admission.

~~(f) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. This paragraph expires January 1, 2020.~~

~~(g) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit. This paragraph expires January 1, 2020.~~

~~(h) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year. This paragraph expires January 1, 2020.~~

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

Sec. 49. Minnesota Statutes 2024, section 144.562, subdivision 3, is amended to read:

Subd. 3. **Approval of license condition.** (a) The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision.

(b) The hospital must meet the eligibility criteria in subdivision 2.

(c) The hospital must be in compliance with the Medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 482.66.

(d) Except as provided in section 144.5621, the hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of Medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to extend a patient's length of stay must be requested by the hospital at least ten days prior to the end of the maximum length of stay.

(e) Except as provided in section 144.5621, the hospital must agree, in writing, to limit admission to a swing bed only to (1) patients who have been hospitalized and not yet discharged from the facility, or (2) patients who are transferred directly from an acute care hospital.

(f) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

(g) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, Medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

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

Sec. 50. **[144.5621] SWING BED APPROVAL; EXCEPTIONS.**

The conditions and limitations in section 144.562, paragraphs (d) and (e), do not apply to any hospital located in Cook County that:

(1) is designated as a critical access hospital under section 144.1483, clause (9), and United States Code, title 42, section 1395i-4; and

(2) has an attached nursing home.

Any swing bed located in a hospital described in this section may be used to provide nursing care without requiring a prior hospital stay. The nursing care provided to a patient in a swing bed is a covered medical assistance service under section 256B.0625, subdivision 2b.

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

Sec. 51. Minnesota Statutes 2024, section 144.563, is amended to read:

144.563 NURSING SERVICES PROVIDED IN A HOSPITAL; PROHIBITED PRACTICES.

A hospital that has been granted a license condition under section 144.562 or 144.5621 must not provide to patients not reimbursed by Medicare or medical assistance the types of services that would be usually and customarily provided and reimbursed under medical assistance or Medicare as services of a skilled nursing facility or intermediate care facility for more than 42 days and only for patients who have been hospitalized and no longer require an acute level of care. Permission to extend a patient's length of stay may be granted by the commissioner if requested by the physician at least ten days prior to the end of the maximum length of stay.

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

Sec. 52. Minnesota Statutes 2024, section 144E.35, is amended to read:

144E.35 REIMBURSEMENT TO AMBULANCE SERVICES FOR ~~VOLUNTEER~~ EDUCATION COSTS.

Subdivision 1. **~~Repayment for volunteer~~ Reimbursement for education costs; ambulance service eligibility.** ~~A licensed ambulance service shall be reimbursed by the director for the necessary expense of the initial education of a volunteer ambulance attendant upon successful completion by the attendant of an EMT education course, or a continuing education course for EMT care, or both, which has been approved by the director, pursuant to section 144E.285~~ (a) Except as provided in subdivision 3, the director must reimburse all eligible Minnesota licensed ambulance services that apply for reimbursement under this section for the necessary expenses of initial EMR and EMT education and EMR and EMT continuing education for ambulance attendants who satisfy the criteria in subdivision 2. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the education course, and other necessary expenditures, except that in no instance shall a ~~volunteer~~ licensed ambulance ~~attendant~~ service be reimbursed more than ~~$900~~:

(1) $1,200 for an ambulance attendant's successful completion of an initial EMT education course~~, and $375~~;

(2) $400 for an ambulance attendant's successful completion of ~~a~~ an EMT continuing education course;

(3) $600 for an ambulance attendant's successful completion of an initial EMR education course; and

(4) $200 for an ambulance attendant's successful completion of an EMR continuing education course.

(b) To be eligible for reimbursement, a licensed ambulance service must have responded to 5,000 or fewer calls in the most recent calendar year.

Subd. 2. **~~Reimbursement provisions~~ Ambulance attendant criteria.** Reimbursement must be paid under ~~provisions of~~ this section when documentation is provided to the director that the ~~individual~~ ambulance attendant:

(1) successfully completed an initial EMR or EMT education course approved by the director under section 144E.285, a continuing education course for EMR or EMT care approved by the director under section 144E.285, or both; and

(2) has served for one year from the date of the final certification exam as an active member of a Minnesota licensed ambulance service.

Subd. 3. **Discontinuance of reimbursement.** If the state is unable to meet its financial obligations under subdivision 1 as the obligations become due, the director must discontinue reimbursing ambulance services for education costs until the state is again able to meet the financial obligations under subdivision 1 as the obligations become due. An ambulance service whose application is not approved due to lack of funding may resubmit the application in the next fiscal year.

Sec. 53. **[144E.38] AMBULANCE SERVICE TRAINING AND STAFFING GRANT PROGRAM.**

Subdivision 1. **Definition.** For purposes of this section, "employee" has the meaning given in section 181.960, subdivision 2.

Subd. 2. **Grant program.** The director must establish and administer a program to award grants to eligible ambulance services for certain costs to train ambulance service employees as emergency medical technicians and staff the ambulance service.

Subd. 3. **Eligible ambulance services.** To be eligible for a grant under this section, an ambulance service must:

(1) be licensed under this chapter; and

(2) in the calendar year prior to the year in which the ambulance service first applies for a grant under this section, have had at least 50 percent of its staffing provided by emergency medical technicians.

Subd. 4. **Application.** An eligible ambulance service seeking a grant under this section must apply to the director in a form and manner and according to a timeline specified by the director. In its application, the eligible ambulance service must specify the number of individuals it plans to hire using the grant money, the number of employee training hours it plans to fund using the grant money, and other information required by the director.

Subd. 5. **Allowable uses of grant money; maximum grant amount.** (a) An ambulance service must use grant money awarded under this section only for one or more of the following:

(1) tuition for employees attending an emergency medical technician (EMT) education program approved by the director;

(2) employee examination fees for EMT certification;

(3) fees for background studies for new EMT employees; and

(4) incurred wage and benefit costs of employees while attending an EMT education program or program-related activities. Wage and benefit costs under this clause must be commensurate with the wages and benefits the ambulance service provides to an entry-level EMT and must not exceed $26 per hour.

(b) The grant amount awarded to an ambulance service must not exceed the amount needed for the costs in paragraph (a).

Subd. 6. **Grant program oversight.** An ambulance service receiving a grant under this section must provide the director with information necessary for the director to administer and evaluate the grant program.

Subd. 7. **Reporting to municipalities.** (a) In order to be eligible to receive a grant under this section, an ambulance service must collect and provide prehospital care data for all emergency responses provided by the licensee within the boundaries of each municipality in the licensee's primary service area. For purposes of this subdivision, "municipality" means a city or town.

(b) A licensee must collect and report the following prehospital care data items as provided in paragraph (a):

(1) total number of emergency ambulance calls;

(2) dispatch reason;

(3) type of emergency service requested for each emergency ambulance call;

(4) response mode to scene;

(5) fee schedule for service;

(6) percent transport disposition;

(7) transport destination;

(8) unit hour utilization by service area; and

(9) mutual aid given and received by municipality.

(c) A licensee must provide the report of prehospital care data of all data items listed in paragraph (b) to the governing body of the municipality by February 15 of each year.

Sec. 54. Minnesota Statutes 2024, section 144G.45, subdivision 6, is amended to read:

Subd. 6. **New construction; plans.** (a) For all new licensure and construction beginning on or after August 1, 2021, the following must be provided to the commissioner:

(1) architectural and engineering plans and specifications for new construction must be prepared and signed by architects and engineers who are registered in Minnesota. Final working drawings and specifications for proposed construction must be submitted to the commissioner for review and approval;

(2) final architectural plans and specifications must include elevations and sections through the building showing types of construction, and must indicate dimensions and assignments of rooms and areas, room finishes, door types and hardware, elevations and details of nurses' work areas, utility rooms, toilet and bathing areas, and large-scale layouts of dietary and laundry areas. Plans must show the location of fixed equipment and sections and details of elevators, chutes, and other conveying systems. Fire walls and smoke partitions must be indicated. The roof plan must show all mechanical installations. The site plan must indicate the proposed and existing buildings, topography, roadways, walks and utility service lines; and

(3) final mechanical and electrical plans and specifications must address the complete layout and type of all installations, systems, and equipment to be provided. Heating plans must include heating elements, piping, thermostatic controls, pumps, tanks, heat exchangers, boilers, breeching, and accessories. Ventilation plans must include room air quantities, ducts, fire and smoke dampers, exhaust fans, humidifiers, and air handling units. Plumbing plans must include the fixtures and equipment fixture schedule; water supply and circulating piping, pumps, tanks, riser diagrams, and building drains; the size, location, and elevation of water and sewer services; and the building fire protection systems. Electrical plans must include fixtures and equipment, receptacles, switches, power outlets, circuits, power and light panels, transformers, and service feeders. Plans must show location of nurse call signals, cable lines, fire alarm stations, and fire detectors and emergency lighting.

(b) Unless construction is begun within one year after approval of the final working drawing and specifications, the drawings must be resubmitted for review and approval.

(c) The commissioner must be notified within 30 days before completion of construction so that the commissioner can make arrangements for a final inspection by the commissioner.

(d) At least one set of complete life safety plans, including changes resulting from remodeling or alterations, must be kept on file in the facility.

(e) For new construction beginning on or after July 1, 2025, the licensee must comply with section 144.554 to submit applicable construction plans and fees to the commissioner.

Sec. 55. **[145.9231] EPILEPSY AND RELATED SEIZURE DISORDERS; DATA COLLECTION AND STATE COORDINATION PLAN.**

Subdivision 1. **Data collection.** The commissioner of health must collect, analyze, and report data on epilepsy and related seizure disorders in Minnesota. The data must include number of diagnoses, clinical outcomes, mortality rates, and related population health data for each calendar year. De-identified data must be made publicly available.

Subd. 2. **State coordination plan.** The commissioner of health must use the data on epilepsy and seizure disorders to inform statewide efforts and build coordinated systems and partnerships to support community-led and culturally responsive strategies to ensure that Minnesotans at risk for or living with epilepsy and seizure disorders and their caregivers have equitable access to opportunities and resources to support their well-being and quality of life. The commissioner of health must evaluate the data to determine the effectiveness of the strategies.

Sec. 56. Minnesota Statutes 2024, section 157.16, subdivision 2, is amended to read:

Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts shall be issued on an annual basis. Any person who operates a place of business after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of ~~$60~~ $100 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of ~~$120~~ $200 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, youth camps, public pools, and resorts operating without a license for a period of up to 30 days. A late fee of ~~$360~~ $450 shall be added to the license fee for establishments operating more than 30 days without a license.

Sec. 57. Minnesota Statutes 2024, section 157.16, subdivision 2a, is amended to read:

Subd. 2a. **Food manager certification.** An applicant for certification or certification renewal as a food manager must submit to the commissioner a ~~$35~~ $45 nonrefundable certification fee payable to the Department of Health. The commissioner shall issue a duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant submits a completed application on a form provided by the commissioner for a duplicate certificate and pays ~~$20~~ $25 to the department for the cost of duplication. In addition, a $5 technology fee must be paid with the initial certification, certification renewal, or duplicate certificate application.

Sec. 58. Minnesota Statutes 2024, section 157.16, subdivision 3, is amended to read:

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base fee of ~~$165~~ $300.

(c) A special event food stand shall pay a flat fee of ~~$55~~ $75 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand and a school concession stand, and each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each fee category, additional food service, or required additional inspection specified in this paragraph:

(1) Category 1 establishment, ~~$110~~ $185. "Category 1 establishment" means a fee category that provides one or more of the following items or is one of the listed establishments or facilities:

(i) serves prepackaged food that is served in the package;

(ii) serves a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(iii) serves soft drinks, coffee, or nonalcoholic beverages;

(iv) provides cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site;

(v) a food establishment where the method of food preparation meets the definition of a low-risk establishment in section 157.20; or

(vi) operates as a child care facility licensed under section 142B.05 and Minnesota Rules, chapter 9503.

(2) Category 2 establishment, ~~$245~~ $430. "Category 2 establishment" means an establishment that is not a Category 1 establishment and is either:

(i) a food establishment where the method of food preparation meets the definition of a medium-risk establishment in section 157.20; or

(ii) an elementary or secondary school as defined in section 120A.05.

(3) Category 3 establishment, ~~$385~~ $670. "Category 3 establishment" means an establishment that is not a Category 1 or Category 2 establishment and is either:

(i) a food establishment where the method of food preparation meets the definition of a high-risk establishment in section 157.20; or

(ii) an establishment where 500 or more meals are prepared per day and served at one or more separate locations.

(4) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~$85~~ $150.

(5) Lodging per sleeping accommodation unit, ~~$11~~ $15, including hotels, motels, lodging establishments, and resorts, up to a maximum of ~~$1,100~~ $1,500. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(6) First public pool, ~~$355~~ $455; each additional public pool, ~~$200~~ $300. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

(7) First spa, ~~$200~~ $300; each additional spa, ~~$110~~ $200. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(8) Private sewer or water, ~~$60~~ $85. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(9) Additional food service, ~~$175~~ $250. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve beverages or food to the public. Additional food service does not apply to school concession stands.

(10) Additional inspection fee, ~~$250~~ $350. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.

(11) HACCP verification, ~~$175~~ $225. "HACCP verification" means an annual fee category for a business that performs one or more specialized process that requires an HACCP plan as required in chapter 31 and Minnesota Rules, chapter 4626.

(e) A fee for review of construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units. Plans submitted less than 30 days prior to construction are subject to 50 percent of the original plan review fee. A fee for review of an HACCP plan for specialized processing must be submitted and approved prior to preparing and serving the specialized processed food for human consumption. The fees for construction plan reviews and HACCP plan reviews are as follows:

Service Area	**Type**	**Fee**
Food	category 1 establishment	~~$400~~ $550
	category 2 establishment	~~$450~~ $750
	category 3 food establishment	~~$500~~ $800
	additional food service	~~$250~~ $400
	HACCP Plan Review	~~$500~~ $600
Transient food service	food cart	~~$250~~ $500
	seasonal permanent food stand	~~$250~~ $500

		~~$250~~
	seasonal temporary food stand	$500
		~~$350~~
	mobile food unit	$700
		~~$375~~
Lodging	less than 25 rooms	$450
		~~$400~~
	25 to less than 100 rooms	$500
		~~$500~~
	100 rooms or more	$600
		~~$350~~
	less than five cabins	$400
		~~$400~~
	five to less than ten cabins	$450
		~~$450~~
	ten cabins or more	$500

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units are extensively remodeled, a fee must be submitted with the remodeling plans. The fee for this construction plan review is as follows:

Service Area	**Type**	**Fee**
		~~$300~~
Food	category 1 establishment	$450
		~~$350~~
	category 2 establishment	$500
		~~$400~~
	category 3 establishment	$550
		~~$250~~
	additional food service	$400
		~~$250~~
Transient food service	food cart	$400
		~~$250~~
	seasonal permanent food stand	$400
		~~$250~~
	seasonal temporary food stand	$400
		~~$250~~
	mobile food unit	$400
		~~$250~~
Lodging	less than 25 rooms	$300
		~~$300~~
	25 to less than 100 rooms	$350
		~~$450~~
	100 rooms or more	$500

		~~$250~~
	less than five cabins	$300
		~~$350~~
	five to less than ten cabins	$400
		~~$400~~
	ten cabins or more	$450

(g) Special event food stands are not required to submit construction or remodeling plans for review.

(h) Youth camps shall pay an annual single fee for food and lodging as follows:

(1) camps with up to 99 campers, ~~$325~~ $375;

(2) camps with 100 to 199 campers, ~~$550~~ $600; and

(3) camps with 200 or more campers, ~~$750~~ $800.

(i) A youth camp which pays fees under paragraph (d) is not required to pay fees under paragraph (h).

Sec. 59. Minnesota Statutes 2024, section 157.16, subdivision 3a, is amended to read:

Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a ~~$40~~ $50 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Sec. 60. Minnesota Statutes 2024, section 157.16, is amended by adding a subdivision to read:

Subd. 3b. **Technology fee.** Every food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, and resort licensed under this chapter must pay a $5 technology fee for each licensed activity for the initial license and with each renewal.

Sec. 61. Minnesota Statutes 2024, section 256B.0625, subdivision 2, is amended to read:

Subd. 2. **Skilled and intermediate nursing care.** ~~(a)~~ Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with

developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. ~~Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.~~

~~(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician, advanced practice registered nurse, or physician assistant certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.~~

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

Sec. 62. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 2b. **Nursing care provided to a patient in a swing bed.** (a) Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless:

(1) the facility where the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds;

(2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments;

(3) the patient was screened as provided by law;

(4) the patient no longer requires acute care services; and

(5) no nursing home beds are available within 25 miles of the facility.

(b) The commissioner shall exempt a facility from compliance with the sole community provider requirement in paragraph (a), clause (1), if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(c) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if:

(1) the patient's physician, advanced practice registered nurse, or physician assistant certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family;

(2) no open nursing home beds are available within 25 miles of the facility; and

(3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

(d) The commissioner shall exempt any facility described under section 144.5621 from compliance with the requirements of paragraph (a), clauses (3) and (5), and paragraph (c), and medical assistance covers an unlimited number of days of nursing care provided to a patient in a swing bed at a facility described under section 144.5621.

(e) The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

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

Sec. 63. Minnesota Statutes 2024, section 256R.01, is amended by adding a subdivision to read:

Subd. 1a. **Payment rates for nursing care provided to a patient in a swing bed.** Payment rates paid to any hospital for nursing care provided to a patient in a swing bed must be those rates established pursuant to section 256B.0625, subdivision 2b.

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

Sec. 64. Minnesota Statutes 2024, section 326.72, subdivision 1, is amended to read:

Subdivision 1. **When license required.** ~~A person within the state intending to directly perform or cause to be performed through subcontracting or similar delegation any asbestos-related work either for financial gain or with respect to the person's own property shall first apply for and obtain a license from the commissioner. The license shall be in writing, be dated when issued, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued.~~

~~The domiciled owner of a single family residence is not required to hold a license or pay a project permit fee to conduct asbestos-related work in the domiciled residence.~~

Any person performing any asbestos-related work within the state must be licensed by the commissioner, whether directly performing asbestos work or causing it to be performed through subcontracting or similar delegation. A domiciled owner of a single-family residence is not required to hold a license or pay a project permit fee to conduct asbestos-related work in the domiciled residence.

Sec. 65. Minnesota Statutes 2024, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~two~~ three percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material on pipes, or greater than six but less than 160 square feet of asbestos-containing material on other facility components, a person shall pay a project permit fee of $35 to the commissioner.

Sec. 66. Minnesota Statutes 2024, section 326.75, subdivision 3a, is amended to read:

Subd. 3a. **Asbestos-related training course permit fee.** ~~The commissioner shall establish by rule a permit fee to be paid by~~ A training course provider shall pay the commissioner a fee of $500 on application for a training course permit ~~or~~ and $250 for the renewal of a permit of each asbestos-related training course required for certification or registration.

Sec. 67. Minnesota Statutes 2024, section 327.15, subdivision 3, is amended to read:

Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The following fees are required for manufactured home parks and recreational camping areas licensed under this chapter. Fees collected under this section shall be deposited in the state government special revenue fund. Recreational camping areas and manufactured home parks shall pay the highest applicable base fee under paragraph (b). The license fee for new operators of a manufactured home park or recreational camping area previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All manufactured home parks and recreational camping areas shall pay the following annual base fee:

(1) a manufactured home park, ~~$165~~ $280; and

(2) a recreational camping area with:

(i) 24 or less sites, ~~$55~~ $100;

(ii) 25 to 99 sites, ~~$230~~ $410; and

(iii) 100 or more sites, ~~$330~~ $610.

In addition to the base fee, manufactured home parks and recreational camping areas shall pay ~~$5~~ $8 for each licensed site. This paragraph does not apply to special event recreational camping areas. Operators of a manufactured home park or a recreational camping area also licensed under section 157.16 for the same location shall pay only one base fee, whichever is the highest of the base fees found in this section or section 157.16.

(c) In addition to the fee in paragraph (b), each manufactured home park or recreational camping area shall pay an additional annual fee for each fee category specified in this paragraph:

(1) Manufactured home parks and recreational camping areas with public swimming pools and spas shall pay the appropriate fees specified in section 157.16.

(2) Individual private sewer or water, ~~$60~~ $85. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface sewage treatment system which uses subsurface treatment and disposal.

(d) The following fees must accompany a plan review application for initial construction of a manufactured home park or recreational camping area:

(1) for initial construction of less than 25 sites, ~~$375~~ $400;

(2) for initial construction of 25 to 99 sites, ~~$400~~ $425; and

(3) for initial construction of 100 or more sites, ~~$500~~ $525.

(e) The following fees must accompany a plan review application when an existing manufactured home park or recreational camping area is expanded:

(1) for expansion of less than 25 sites, ~~$250~~ $300;

(2) for expansion of 25 to 99 sites, ~~$300~~ $350; and

(3) for expansion of 100 or more sites, ~~$450~~ $500.

Sec. 68. Minnesota Statutes 2024, section 327.15, subdivision 4, is amended to read:

Subd. 4. **Fees, special event recreational camping areas.** (a) The following fees are required for special event recreational camping areas licensed under this chapter.

(b) All special event recreational camping areas shall pay an annual fee of ~~$150~~ $250 plus ~~$1~~ $4 for each licensed site.

(c) A special event recreational camping area shall pay a late fee of ~~$360~~ $450 for failing to obtain a license prior to operating.

(d) The following fees must accompany a plan review application for initial construction of a special event recreational camping area:

(1) for initial construction of less than 25 special event recreational camping sites, ~~$375~~ $475;

(2) for initial construction of 25 to 99 sites, ~~$400~~ $500; and

(3) for initial construction of 100 or more sites, ~~$500~~ $600.

(e) The following fees must accompany a plan review application for expansion of a special event recreational camping area:

(1) for expansion of less than 25 sites, ~~$250~~ $300;

(2) for expansion of 25 to 99 sites, ~~$300~~ $350; and

(3) for expansion of 100 or more sites, ~~$450~~ $500.

Sec. 69. Minnesota Statutes 2024, section 327.15, is amended by adding a subdivision to read:

Subd. 5. **Technology fee.** All manufactured home parks, recreational camping areas, and special event camping areas must pay a $5 technology fee at initial licensing and upon each renewal.

Sec. 70. **SPOKEN LANGUAGE HEALTH CARE INTERPRETER WORK GROUP.**

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

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

(c) "Common languages" means the 15 most frequent languages without regard to dialect in Minnesota.

(d) "Registered interpreter" means a spoken language interpreter who is listed on the Department of Health's spoken language health care interpreter roster.

(e) "Work group" means the spoken language health care interpreter work group established in subdivision 2.

Subd. 2. **Composition.** The commissioner shall, after receiving work group candidate applications, appoint 15 members to the work group consisting of the following members:

(1) three members who are interpreters listed on the Department of Health's spoken language health care interpreter roster and who are Minnesota residents. Of these members: (i) each must be an interpreter for a different language; (ii) at least one must have a national certification credential; and (iii) at least one must have been listed on the roster as an interpreter in a language other than the common languages and must have completed a nationally recognized training program for health care interpreters that is, at a minimum, 40 hours in length;

(2) three members representing limited English proficiency (LEP) individuals. Of these members, two must represent LEP individuals who are not proficient in a common language and one must represent LEP individuals who are proficient in a language that is not one of the common languages;

(3) one member representing a health plan company;

(4) one member representing a Minnesota health system who is not an interpreter;

(5) two members representing interpreter agencies, including one member representing agencies whose main office is located outside the seven-county metropolitan area and one member representing agencies whose main office is located within the seven-county metropolitan area;

(6) one member representing the Department of Health;

(7) one member representing the Department of Human Services;

(8) one member representing an interpreter training program or postsecondary educational institution program providing interpreter courses or skills assessment;

(9) one member who is affiliated with a Minnesota-based or Minnesota chapter of a national or international organization representing interpreters; and

(10) one member who is a licensed direct care health provider.

Subd. 3. **Duties.** The work group must compile a list of recommendations to support and improve access to the critical health care interpreting services provided across the state, including but not limited to:

(1) changing requirements for registered and certified interpreters to reflect changing needs of the Minnesota health care community and emerging national standards of training, competency, and testing;

(2) addressing barriers for interpreters to gain access to the roster, including barriers to interpreters of uncommon languages and interpreters in rural areas;

(3) reimbursing spoken language health care interpreting;

(4) identifying gaps in interpreter services in rural areas and recommending ways to address interpreter training and funding needs;

(5) providing training, certification, and continuing education programs;

(6) convening a meeting of public and private sector representatives of the spoken language health care interpreters community to identify ongoing sources of financial assistance to aid individual interpreters in meeting interpreter training and testing registry requirements;

(7) conducting surveys of people receiving and providing interpreter services to understand changing needs and consumer quality care; and

(8) suggesting changes in requirements and qualifications on telehealth or remote interpreting.

Subd. 4. **Compensation; expense reimbursement.** Compensation shall be offered to work group members not being compensated for their participation in work group activities as part of their existing job duties. Work group members shall be compensated and reimbursed for expenses for work group activities under section 15.059, subdivision 3.

Subd. 5. **Administrative support; meeting space; meeting facilitation.** The commissioner must provide meeting space and administrative support for the work group. The commissioner may contract with a neutral independent consultant to provide this administrative support and to facilitate and lead the meetings of the work group.

Subd. 6. **Deadline for appointments.** The commissioner must appoint members to the work group by August 15, 2025.

Subd. 7. **Expiration.** This section expires on November 2, 2026, or upon submission of the report required under subdivision 9, whichever is earlier.

Subd. 8. **Initial spoken language health care interpreter work group meetings.** The commissioner shall convene the first meeting of the work group by October 1, 2025. Prior to the first meeting, work group members must receive survey results and evidence-based research on interpreter services in Minnesota. During the first meetings, work group members must receive survey results and consult with subject matter experts, including but not limited to signed language interpreting experts, academic experts with knowledge of interpreting research, and academic health experts to address specific gaps in spoken language health care interpreting. The work group shall provide a minimum of two opportunities for public comment. These opportunities shall be announced with at least four weeks' notice, with publicity in the five most common languages in Minnesota. Interpreters for those same languages shall be provided during the public comment opportunities.

Subd. 9. **Report.** The commissioner must provide the chairs and ranking minority members of the legislative committees with jurisdiction over health care interpreter services with recommendations, including draft legislation and any statutory changes needed to implement the recommendations, to improve and support access to health care interpreting services statewide by November 1, 2026.

Sec. 71. **AFRICAN AMERICAN-FOCUSED HOMEPLACE GRANT PROGRAM.**

(a) The commissioner of health must establish a grant program to strengthen and implement the current model of the African American-focused Homeplace in Hennepin County. The purpose of the model is to improve access to culturally centered healing and

care during pregnancy and the postpartum period, with the goal of improving maternal and child health outcomes.

(b) By December 15, 2026, the grantee must submit a report to the commissioner of health on the implementation and progress of Homeplace in Hennepin County. The report must outline outcomes achieved and recommendations for future funding and program expansion.

Sec. 72. **RULEMAKING.**

The Department of Health must adopt rules using the expedited process under Minnesota Statutes, section 14.389, to amend certain parts in Minnesota Rules, chapter 4695, to conform with the changes made in this act.

Sec. 73. **REPEALER.**

(a) Minnesota Statutes 2024, sections 62J.824; and 103I.550, are repealed.

(b) Minnesota Rules, part 4695.2900, is repealed.

ARTICLE 2
DEPARTMENT OF HEALTH POLICY

Section 1. Minnesota Statutes 2024, section 62J.461, subdivision 3, is amended to read:

Subd. 3. **Reporting by covered entities to the commissioner.** (a) Each 340B covered entity shall report to the commissioner by April 1 of each year the following information for transactions conducted by the 340B covered entity or on its behalf, and related to its participation in the federal 340B program for the previous calendar year:

(1) the aggregated acquisition cost for prescription drugs obtained under the 340B program;

(2) the aggregated payment amount received for drugs obtained under the 340B program and dispensed or administered to patients~~;~~:

(i) that are net of the contracted price for insurance claims payments; and

(ii) that reflect the portion of payment received from grants, cash, or other payment types that relate to the dispensing or administering of drugs obtained under the 340B program;

(3) the number of pricing units dispensed or administered for prescription drugs described in clause (2); and

(4) the aggregated payments made:

(i) to contract pharmacies to dispense drugs obtained under the 340B program;

(ii) to any other entity that is not the covered entity and is not a contract pharmacy for managing any aspect of the covered entity's 340B program; and

(iii) for ~~all~~ other internal, direct expenses related to administering the 340B program with a detailed description of the direct costs included.

The information under clauses (2) and (3) must be reported by payer type, including but not limited to commercial insurance, medical assistance, MinnesotaCare, and Medicare, in the form and manner prescribed by the commissioner.

(b) For covered entities that are hospitals, the information required under paragraph (a), clauses (1) to (3), must also be reported at the national drug code level for the 50 most frequently dispensed or administered drugs by the facility under the 340B program.

(c) Data submitted to the commissioner under paragraphs (a) and (b) are classified as nonpublic data, as defined in section 13.02, subdivision 9.

Sec. 2. Minnesota Statutes 2024, section 62J.461, subdivision 4, is amended to read:

Subd. 4. **Enforcement and exceptions.** (a) Any ~~health care~~ covered entity subject to reporting under this section that fails to provide data in the form and manner prescribed by the commissioner is subject to the levy of a fine ~~paid to the commissioner~~ of up to $500 for each day the data are past due. Any fine levied against the entity under this subdivision is subject to the contested case and judicial review provisions of sections 14.57 ~~and~~ to 14.69.

(b) The commissioner may grant an entity an extension of or exemption from the reporting obligations under this ~~subdivision~~ section, upon a showing of good cause by the entity.

Sec. 3. Minnesota Statutes 2024, section 62J.461, subdivision 5, is amended to read:

Subd. 5. **Reports to the legislature.** By November 15, 2024, and by November 15 of each year thereafter, the commissioner shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy, a report that aggregates the data submitted under subdivision 3, paragraphs (a) and (b). ~~The following information must be included in the report~~ For all 340B entities whose net 340B revenue constitutes a significant share, as determined by the commissioner, of all net 340B revenue across all 340B covered entities in Minnesota, the following information must also be included in the report:

(1) the information submitted under subdivision 2; and

(2) for each 340B entity identified in subdivision 2, that entity's 340B net revenue as calculated using the data submitted under subdivision 3, paragraph (a), with net revenue being subdivision 3, paragraph (a), clause (2), less the sum of subdivision 3, paragraph (a), clauses (1) and (4).

For all other entities, the data in the report must be aggregated to the entity type or groupings of entity types in a manner that prevents the identification of an individual entity and any entity's specific data value reported for an individual data element.

Sec. 4. Minnesota Statutes 2024, section 62J.51, subdivision 19a, is amended to read:

Subd. 19a. **Uniform explanation of benefits ~~document~~.** "Uniform explanation of benefits ~~document~~" means either the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered or its electronic equivalent under section 62J.581, which is sent to a patient.

Sec. 5. Minnesota Statutes 2024, section 62J.581, is amended to read:

62J.581 STANDARDS FOR MINNESOTA UNIFORM HEALTH CARE REIMBURSEMENT DOCUMENTS.

Subdivision 1. **Minnesota uniform remittance advice.** All group purchasers shall provide a uniform claim payment/advice transaction to health care providers when a claim is adjudicated. The uniform claim payment/advice transaction shall comply with section 62J.536, subdivision 1, paragraph (b), and rules adopted under section 62J.536, subdivision 2.

Subd. 2. **Minnesota uniform explanation of benefits ~~document~~.** (a) All group purchasers shall provide a uniform explanation of benefits ~~document~~ to health care patients when an explanation of benefits ~~document~~ is provided as otherwise required or permitted by law. The uniform explanation of benefits ~~document~~ shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections 62J.50 to 62J.61, the ~~uniform claim payment/advice transaction and~~ uniform explanation of benefits ~~document~~ format specified in subdivision 4 shall apply to all health care services delivered by a health care provider

or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in ~~subdivisions 1 and~~ subdivision 2 if they comply with section 62A.01, subdivisions 2 and 3.

Subd. 4. **Specifications.** (a) The uniform explanation of benefits ~~document~~ shall be provided by use of a paper document conforming to the specifications in this section or its electronic equivalent under paragraph (b).

(b) Group purchasers may make the uniform explanation of benefits available in a version that can be accessed by health care patients electronically if:

(1) the group purchaser making the uniform explanation of benefits available electronically provides health care patients the ability to choose whether to receive paper, electronic, or both paper and electronic versions of their uniform explanation of benefits;

(2) the group purchaser provides clear, readily accessible information and instructions for the patient to communicate their choice; and

(3) health care patients not responding to the opportunity to make a choice will receive at a minimum a paper uniform explanation of benefits.

(c) The commissioner, after consulting with the Administrative Uniformity Committee, shall specify the data elements and definitions for the paper uniform explanation of benefits ~~document. The commissioner and the Administrative Uniformity Committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform claim payment/advice transaction for dental care services.~~ Any electronic version of the uniform explanation of benefits must use the same data elements and definitions as the paper uniform explanation of benefits.

~~Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.~~

Sec. 6. Minnesota Statutes 2024, section 62J.84, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) a new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title 42, section 262(a)(c).

(d) "Commissioner" means the commissioner of health.

(e) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title 42, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

(f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

(g) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration (FDA) for which no previous wholesale acquisition cost has been established for comparison.

(h) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

(j) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

(k) "30-day supply" means the total daily dosage units of a prescription drug recommended by the prescribing label approved by the FDA for 30 days. If the FDA-approved prescribing label includes more than one recommended daily dosage, the

30-day supply is based on the maximum recommended daily dosage on the FDA-approved prescribing label.

(l) "Course of treatment" means the total dosage of a single prescription for a prescription drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing label includes more than one recommended dosage for a single course of treatment, the course of treatment is the maximum recommended dosage on the FDA-approved prescribing label.

(m) "Drug product family" means a group of one or more prescription drugs that share a unique generic drug description or nontrade name and dosage form.

~~(n) "Individual salable unit" means the smallest container of product introduced into commerce by the manufacturer or repackager that is intended by the manufacturer or repackager for individual sale to a dispenser.~~

~~(o)~~ (n) "National drug code" means the three-segment code maintained by the federal Food and Drug Administration that includes a labeler code, a product code, and a package code for a drug product and that has been converted to an 11-digit format consisting of five digits in the first segment, four digits in the second segment, and two digits in the third segment. A three-segment code shall be considered converted to an 11-digit format when, as necessary, at least one "0" has been added to the front of each segment containing less than the specified number of digits such that each segment contains the specified number of digits.

~~(p)~~ (o) "Pharmacy" or "pharmacy provider" means a community/outpatient pharmacy as defined in Minnesota Rules, part 6800.0100, subpart 2, that is also licensed as a pharmacy by the Board of Pharmacy under section 151.19.

~~(q)~~ (p) "Pharmacy benefit manager" or "PBM" means an entity licensed to act as a pharmacy benefit manager under section 62W.03.

~~(r)~~ (q) "Pricing unit" means the smallest dispensable amount of a prescription drug product that could be dispensed or administered.

~~(s)~~ (r) "Rebate" means a discount, chargeback, or other price concession that affects the price of a prescription drug product, regardless of whether conferred through regular aggregate payments, on a claim-by-claim basis at the point of sale, as part of retrospective financial reconciliations, including reconciliations that also reflect other contractual arrangements, or by any other method. "Rebate" does not mean a bona fide service fee as defined in Code of Federal Regulations, title 42, section 447.502.

~~(t)~~ (s) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefit manager, wholesale drug distributor, or any other entity required to submit data under this section.

~~(u)~~ (t) "Wholesale drug distributor" or "wholesaler" means an entity that~~:~~

~~(1)~~ is licensed to act as a wholesale drug distributor under section 151.47~~; and~~.

~~(2) distributes prescription drugs, for which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state.~~

Sec. 7. Minnesota Statutes 2024, section 62J.84, subdivision 3, is amended to read:

Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022, a drug manufacturer must submit to the commissioner the information described in paragraph (b) for each prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for brand name drugs where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in the price over the previous 24-month period; and

(2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the price increase goes into effect, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the description and price of the drug and the net increase, expressed as a percentage, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the year the prescription drug was introduced for sale in the United States;

~~(4)~~ (5) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

~~(5)~~ (6) the direct costs incurred during the previous 12-month period by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(7) the number of units of the prescription drug sold during the previous 12-month period;

~~(6)~~ (8) the total sales revenue for the prescription drug during the previous 12-month period;

(9) the total rebate payable amount accrued for the prescription drug during the previous 12-month period;

~~(7)~~ (10) the manufacturer's net profit attributable to the prescription drug during the previous 12-month period;

~~(8)~~ (11) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the previous 12-month period, if applicable;

~~(9)~~ (12) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

~~(10)~~ (13) the patent expiration date of the prescription drug if it is under patent;

~~(11)~~ (14) the name and location of the company that manufactured the drug;

~~(12)~~ (15) if a brand name prescription drug, the highest price paid for the prescription drug during the previous calendar year in the ten countries, excluding the United States, that charged the highest single price for the prescription drug; and

~~(13)~~ (16) if the prescription drug was acquired by the manufacturer during the previous 12-month period, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 8. Minnesota Statutes 2024, section 62J.84, subdivision 6, is amended to read:

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3, 4, and 11 to 14 and the manufacturers of those prescription drugs; ~~and~~

(2) a list of reporting entities that reported prescription drug price information under subdivisions 3, 4, and 11 to 14; and

~~(2)~~ (3) information reported to the commissioner under subdivisions 3, 4, and 11 to 14, aggregated on a per-drug basis in a manner that does not allow the identification of a reporting entity that is not the manufacturer of the drug.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a reporting entity believes information should be withheld from public disclosure pursuant to this paragraph, the reporting entity must clearly and specifically identify that information and describe the legal basis in writing when the reporting entity submits the information under this section. If the commissioner disagrees with the reporting entity's request to withhold information from public disclosure, the commissioner shall provide the reporting entity written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing

the nature of the information and the commissioner's basis for withholding the information from disclosure.

(e) To the extent the information required to be posted under this subdivision is collected and made available to the public by another state, by the University of Minnesota, or through an online drug pricing reference and analytical tool, the commissioner may reference the availability of this drug price data from another source including, within existing appropriations, creating the ability of the public to access the data from the source for purposes of meeting the reporting requirements of this subdivision.

Sec. 9. Minnesota Statutes 2024, section 62J.84, subdivision 10, is amended to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the commissioner determines to represent a substantial public interest and for which the commissioner intends to request data under subdivisions 11 to 14, subject to paragraph (c). The commissioner shall base its inclusion of prescription drugs on any information the commissioner determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the commissioner shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;

(2) for which average claims paid amounts exceeded 125 percent of the price as of the claim incurred date during the most recent calendar quarter for which claims paid amounts are available; or

(3) that are identified by members of the public during a public comment process.

(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of:

(1) the requirement to report under subdivisions 11 to 14.; and

(2) the reporting period for which data must be provided.

(c) The commissioner must not designate more than 500 prescription drugs as having a substantial public interest in any one notice.

(d) Notwithstanding subdivision 16, the commissioner is exempt from chapter 14, including section 14.386, in implementing this subdivision.

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

Sec. 10. Minnesota Statutes 2024, section 62J.84, subdivision 11, is amended to read:

Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a manufacturer must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the manufacturer by the department under subdivision 10;

(2) which the manufacturer manufactures or repackages;

(3) for which the manufacturer sets the wholesale acquisition cost; and

(4) for which the manufacturer has not submitted data under subdivision 3 during the 120-day period prior to the date of the notification to report.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the price of the drug product on the later of:

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the year the prescription drug was introduced for sale in the United States;

~~(4)~~ (5) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

~~(5)~~ (6) the direct costs incurred during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

~~(6)~~ (7) the number of units of the prescription drug sold during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

~~(7)~~ (8) the total sales revenue for the prescription drug during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

~~(8)~~ (9) the total rebate payable amount accrued for the prescription drug during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

~~(9)~~ (10) the manufacturer's net profit attributable to the prescription drug during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

~~(10)~~ (11) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report, if applicable;

~~(11)~~ (12) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

~~(12)~~ (13) the patent expiration date of the prescription drug if the prescription drug is under patent;

~~(13)~~ (14) the name and location of the company that manufactured the drug;

~~(14)~~ (15) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

~~(15)~~ (16) if the prescription drug was acquired by the manufacturer within ~~a 12-month period prior to the date of~~ the reporting period specified in the notification to report, all of the following information:

(i) the price at acquisition;

(ii) the price in the calendar year prior to acquisition;

(iii) the name of the company from which the drug was acquired;

(iv) the date of acquisition; and

(v) the acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 11. Minnesota Statutes 2024, section 62J.84, subdivision 12, is amended to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the pharmacy by the department under subdivision 10~~.~~; and

(2) that the pharmacy dispensed in Minnesota or mailed to a Minnesota address.

(b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug acquired during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report; and

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report.

(c) The pharmacy may submit any documentation necessary to support the information reported under this subdivision.

(d) The commissioner may grant extensions, exemptions, or both to compliance with the requirements of paragraphs (a) and (b) by small or independent pharmacies, if compliance with paragraphs (a) and (b) would represent a hardship or undue burden to the pharmacy. The commissioner may establish procedures for small or independent pharmacies to request extensions or exemptions under this paragraph.

Sec. 12. Minnesota Statutes 2024, section 62J.84, subdivision 13, is amended to read:

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the PBM by the department under subdivision 10~~.~~; and

(2) for which the PBM fulfilled pharmacy benefit management duties for Minnesota residents.

(b) For each of the drugs described in paragraph (a), the PBM shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled ~~for which the PBM administered claims~~ during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled ~~for which the PBM administered claims~~ during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(4) the total reimbursement ~~or administrative fee~~ amount~~, or both,~~ accrued and receivable from payers for pricing units of the drug product filled ~~for which the PBM administered claims~~ during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(5) the total administrative fee amount accrued and receivable from payers for pricing units of the drug product filled during the reporting period specified in the notification to report;

~~(5)~~ (6) the total rebate receivable amount accrued by the PBM for the drug product during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report; and

~~(6)~~ (7) the total rebate payable amount accrued by the PBM for the drug product during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report.

(c) The PBM may submit any documentation necessary to support the information reported under this subdivision.

Sec. 13. Minnesota Statutes 2024, section 62J.84, subdivision 14, is amended to read:

Subd. 14. **Wholesale drug distributor prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a wholesale drug distributor that distributes prescription drugs, for which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state, must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the wholesale drug distributor by the department under subdivision 10~~.~~; and

(2) that the wholesale drug distributor distributed within or into Minnesota.

(b) For each of the drugs described in paragraph (a), the wholesale drug distributor shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for ~~this~~ the drug product during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the ~~12-month period prior to the date of~~ reporting period specified in the notification to report.

(c) The wholesale drug distributor may submit any documentation necessary to support the information reported under this subdivision.

Sec. 14. Minnesota Statutes 2024, section 62J.84, subdivision 15, is amended to read:

Subd. 15. **Registration requirements.** ~~Beginning~~ Effective January 1, ~~2024~~ 2026, a reporting entity subject to this chapter shall register, or update existing registration information, with the department in a form and manner prescribed by the commissioner by January 30 each year.

Sec. 15. Minnesota Statutes 2024, section 62K.10, subdivision 2, is amended to read:

Subd. 2. ~~**Primary care; mental health services; general hospital services**~~ **Time and distance standards.** ~~The maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services~~ Health carriers must meet the time and distance standards under Code of Federal Regulations, title 45, section 155.1050.

Sec. 16. Minnesota Statutes 2024, section 62K.10, subdivision 5, is amended to read:

Subd. 5. **Waiver.** (a) A health carrier may apply to the commissioner of health for a waiver of the requirements in subdivision 2 ~~or 3~~ if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $500 for each application to waive the requirements in subdivision 2 ~~or 3~~ for one or more provider types per county, and must:

(1) demonstrate with specific data that the requirement of subdivision 2 ~~or 3~~ is not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address the network inadequacy, and, for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) The commissioner shall establish guidelines for evaluating waiver applications, standards governing approval or denial of a waiver application, and standards for steps that health carriers must take to address the network inadequacy and allow the health carrier to meet network adequacy requirements within a reasonable time period. The commissioner shall review each waiver application using these guidelines and standards and shall approve a waiver application only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for taking these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health carrier demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health carrier is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telehealth, as defined in section 62A.673, subdivision 2.

(d) The waiver shall automatically expire after one year. Upon or prior to expiration of a waiver, a health carrier unable to meet the requirements in subdivision 2 ~~or 3~~ must submit a new waiver application under paragraph (a) and must also submit evidence of steps the carrier took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the carrier for the most recent one-year period, the commissioner shall also examine the steps the carrier took during that one-year period to address network inadequacy, and shall only approve a subsequent waiver application that satisfies the requirements in paragraph (b), demonstrates that the carrier took the steps it proposed to address network inadequacy, and explains why the carrier continues to be unable to satisfy the requirements in subdivision 2 ~~or 3~~.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Sec. 17. Minnesota Statutes 2024, section 62K.10, subdivision 6, is amended to read:

Subd. 6. **Referral centers.** ~~Subdivisions~~ Subdivision 2 ~~and 3~~ shall not apply if an enrollee is referred to a referral center for health care services. A referral center is a medical facility that provides highly specialized medical care, including but not limited to organ transplants. A health carrier or preferred provider organization may consider the volume of services provided annually, case mix, and severity adjusted mortality and morbidity rates in designating a referral center.

Sec. 18. Minnesota Statutes 2024, section 103I.005, subdivision 17b, is amended to read:

Subd. 17b. **Temporary boring.** "Temporary boring" means an excavation that is 15 feet or more in depth, is sealed within 72 hours of the time of construction, and is drilled, cored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring;

(2) monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance;

(3) measure groundwater levels, including use of a piezometer; ~~and~~ or

(4) determine groundwater flow direction or velocity.

Sec. 19. Minnesota Statutes 2024, section 103I.101, subdivision 2, is amended to read:

Subd. 2. **Duties.** The commissioner shall:

(1) regulate the drilling, construction, modification, repair, and sealing of wells and borings;

(2) examine and license:

(i) well contractors;

(ii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

(iii) persons modifying or repairing well casings above the pitless unit or adaptor, well screens, well diameters, and installing well pumps or pumping equipment;

(iv) persons constructing, repairing, and sealing dewatering wells;

(v) persons sealing wells or borings; ~~and~~

(vi) persons excavating or drilling holes for the installation of elevator borings; and

(vii) persons installing, removing, or maintaining groundwater thermal exchange devices and submerged closed loop heat exchangers;

(3) examine and license environmental well contractors;

(4) license explorers engaged in exploratory boring and examine individuals who supervise or oversee exploratory boring;

(5) after consultation with the commissioner of natural resources and the Pollution Control Agency, establish standards for the design, location, construction, repair, and sealing of wells and borings within the state; and

(6) issue permits for wells, groundwater thermal devices, bored geothermal heat exchangers, installation of submerged closed loop heat exchanger systems, and elevator borings.

Sec. 20. Minnesota Statutes 2024, section 103I.101, subdivision 5, is amended to read:

Subd. 5. **Commissioner to adopt rules.** The commissioner shall adopt rules including:

(1) issuance of licenses for:

(i) qualified well contractors;

(ii) persons constructing, repairing, and sealing dewatering wells;

(iii) persons sealing wells or borings;

(iv) persons installing, modifying, or repairing well casings, well screens, well diameters, and well pumps or pumping equipment;

(v) persons constructing, repairing, and sealing bored geothermal heat exchangers;

(vi) persons constructing, repairing, and sealing elevator borings; ~~and~~

(vii) persons constructing, repairing, and sealing environmental wells; and

(viii) persons installing, removing, or maintaining groundwater thermal exchange devices and submerged closed loop heat exchangers;

(2) establishment of conditions for examination and review of applications for license and certification;

(3) establishment of conditions for revocation and suspension of license and certification;

(4) establishment of minimum standards for design, location, construction, repair, and sealing of wells and borings to implement the purpose and intent of this chapter;

(5) establishment of a system for reporting on wells and borings drilled and sealed;

(6) establishment of standards for the construction, maintenance, sealing, and water quality monitoring of wells in areas of known or suspected contamination;

(7) establishment of wellhead protection measures for wells serving public water supplies;

(8) establishment of procedures to coordinate collection of well and boring data with other state and local governmental agencies;

(9) establishment of criteria and procedures for submission of well and boring logs, formation samples or well or boring cuttings, water samples, or other special information required for and water resource mapping; and

(10) establishment of minimum standards for design, location, construction, maintenance, repair, sealing, safety, and resource conservation related to borings, including exploratory borings as defined in section 103I.005, subdivision 9.

Sec. 21. Minnesota Statutes 2024, section 103I.101, is amended by adding a subdivision to read:

Subd. 7. **Inspection.** At a minimum, the commissioner of health shall inspect at least 25 percent of well construction notifications each year under this section.

Sec. 22. Minnesota Statutes 2024, section 138.912, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The healthy eating, here at home program is established to provide incentives for low-income Minnesotans to use federal Supplemental Nutrition Assistance Program (SNAP) or SUN bucks (Summer EBT) benefits for healthy purchases at Minnesota-based farmers' markets, mobile markets, and direct-farmer sales, including community-supported agriculture shares.

Sec. 23. Minnesota Statutes 2024, section 138.912, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Healthy eating, here at home" means a program administered by the ~~Minnesota Humanities Center~~ Department of Health to provide incentives for low-income Minnesotans to use SNAP or SUN bucks (Summer EBT) benefits for healthy purchases at Minnesota-based farmers' markets.

(c) "Healthy purchases" means SNAP-eligible foods.

(d) "Minnesota-based farmers' market" means a physical market as defined in section 28A.151, subdivision 1, paragraph (b), and also includes mobile markets and direct-farmer sales, including through a community-supported agriculture model.

(e) "Voucher" means a physical or electronic credit.

(f) "Eligible household" means an individual or family that is determined to be a recipient of SNAP or SUN bucks (Summer EBT).

Sec. 24. Minnesota Statutes 2024, section 138.912, subdivision 3, is amended to read:

Subd. 3. **Grants.** The ~~Minnesota Humanities Center~~ commissioner shall allocate grant funds to nonprofit organizations that work with Minnesota-based farmers' markets to provide up to $10 vouchers to SNAP or SUN bucks (Summer EBT) participants who use electronic benefits transfer (EBT) cards for healthy purchases. Funds may also be provided for vouchers distributed through nonprofit organizations engaged in healthy cooking and food education outreach to eligible households for use at farmers' markets. Funds appropriated under this section may not be used for healthy cooking classes or food education outreach. When

awarding grants, the ~~Minnesota Humanities Center~~ commissioner must consider how the nonprofit organizations will achieve geographic balance, including specific efforts to reach eligible households across the state, and the organizations' capacity to manage the programming and outreach.

Sec. 25. Minnesota Statutes 2024, section 138.912, subdivision 4, is amended to read:

Subd. 4. **Household eligibility; participation.** To be eligible for a healthy eating, here at home voucher, an eligible household must meet the Minnesota SNAP or SUN bucks (Summer EBT) eligibility requirements ~~under section 142F.10~~.

Sec. 26. Minnesota Statutes 2024, section 138.912, subdivision 6, is amended to read:

Subd. 6. **Program reporting.** The nonprofit organizations that receive grant funds must report annually to the ~~Minnesota Humanities Center~~ commissioner with information regarding the operation of the program, including the number of vouchers issued and the number of people served. To the extent practicable, the nonprofit organizations must report on the usage of the vouchers and evaluate the program's effectiveness.

Sec. 27. Minnesota Statutes 2024, section 144.0758, subdivision 3, is amended to read:

Subd. 3. **Eligible grantees.** (a) Organizations eligible to receive grant funding under this section are Minnesota's Tribal Nations in accordance with paragraph (b) and urban American Indian community-based organizations in accordance with paragraph (c).

(b) Minnesota's Tribal Nations may choose to receive funding under this section according to a noncompetitive funding formula specified by the commissioner.

(c) Urban American Indian community-based organizations are eligible to apply for funding under this section by submitting a proposal for consideration by the commissioner.

Sec. 28. Minnesota Statutes 2024, section 144.50, is amended by adding a subdivision to read:

Subd. 8. **Controlling person.** (a) "Controlling person" includes the following individuals, if applicable, as deemed appropriate by the hospital:

(1) any officer of the organization;

(2) any hospital administrator; and

(3) any managerial official.

(b) Controlling person does not include:

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

(2) government and government-sponsored entities such as the United States Department of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota Housing Finance Agency which provide loans, financing, and insurance products for housing sites;

(3) an individual who is a state or federal official, a state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more hospitals, unless the individual is also an officer, owner, or managerial official of the hospital, receives any remuneration from a hospital, or who is a controlling person not otherwise excluded in this subdivision;

(4) a natural person who is a member of a tax-exempt organization under section 290.05, subdivision 2, unless the individual is also a controlling person not otherwise excluded in this subdivision; and

(5) a natural person who owns less than five percent of the outstanding common shares of a corporation:

(i) whose securities are exempt by virtue of section 80A.45, clause (6); or

(ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

Sec. 29. Minnesota Statutes 2024, section 144.555, subdivision 1a, is amended to read:

Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health, the public, and others at least 182 days before the hospital or hospital campus voluntarily plans to implement one of the scheduled actions listed in paragraph (b), unless the controlling persons can demonstrate to the commissioner that meeting the advanced notice requirement is not feasible and the commissioner approves a shorter advanced notice.

(b) The following scheduled actions require advanced notice under paragraph (a):

(1) ceasing operations;

(2) curtailing operations to the extent that ~~patients~~ inpatients or emergency department services must be relocated;

(3) relocating the provision of inpatient health services or emergency department services to another hospital or ~~another~~ hospital campus; or

(4) ceasing to offer inpatient maternity care and inpatient newborn care services, inpatient intensive care unit services, inpatient mental health services, or inpatient substance use disorder treatment services.

(c) A notice required under this subdivision must comply with the requirements in subdivision 1d.

(d) The commissioner shall cooperate with the controlling persons and advise them about relocating the patients.

(e) For purposes of this subdivision, "inpatient" means services that are provided to a person who has been admitted to a hospital for bed occupancy.

Sec. 30. Minnesota Statutes 2024, section 144.555, subdivision 1b, is amended to read:

Subd. 1b. **Public hearing.** Within 30 days after receiving notice under subdivision 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations, curtailment of operations, relocation of health services, or cessation in offering health services. The commissioner must provide adequate public notice of the hearing in a time and manner determined by the commissioner. The commissioner must ensure that video conferencing technology will be used to allow members of the public to view and participate in the hearing. The controlling persons of the hospital or hospital campus must participate in the public hearing. The public hearing must be held at a location that is within ten miles of the hospital or hospital campus and can accommodate anticipated public attendance or with the commissioner's approval as close as is practicable, and that is provided or arranged by the hospital or hospital campus. ~~Video conferencing technology must be used to allow members of the public to view and participate in the hearing.~~ The public hearing must include:

(1) an explanation by the controlling persons of the reasons for ceasing or curtailing operations, relocating health services, or ceasing to offer any of the listed health services;

(2) a description of the actions that controlling persons will take to ensure that residents in the hospital's or campus's service area have continued access to the health services being eliminated, curtailed, or relocated;

(3) an opportunity for public testimony for at least one hour on the scheduled cessation or curtailment of operations, relocation of health services, or cessation in offering any of

the listed health services, and on the hospital's or campus's plan to ensure continued access to those health services being eliminated, curtailed, or relocated; and

(4) an opportunity for the controlling persons to respond to questions from interested persons.

Sec. 31. Minnesota Statutes 2024, section 144.608, subdivision 2, is amended to read:

Subd. 2. **Council administration.** (a) The council must meet at least twice a year but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

(b) The terms, compensation, and removal of members of the council are governed by section 15.059. The council expires June 30, ~~2025~~ 2035.

(c) The council may appoint subcommittees and work groups. Subcommittees shall consist of council members. Work groups may include noncouncil members. Noncouncil members shall be compensated for work group activities under section 15.059, subdivision 3, but shall receive expenses only.

Sec. 32. Minnesota Statutes 2024, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health; Department of Children, Youth, and Families; and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education; the Department of Health; the Department of Children, Youth, and Families; or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision;

(18) a representative of the Department of Education regional low-incidence facilitators;

(19) a representative from the deaf mentor program; and

(20) a representative of the Minnesota State Academy for the Deaf from the Minnesota State Academies staff.

The commissioner must complete the initial appointments required under this subdivision by September 1, 2007, and the initial appointments under clauses (19) and (20) by September 1, 2019.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

~~(e) This subdivision expires June 30, 2025.~~

EFFECTIVE DATE. This section is effective the day following final enactment or June 30, 2025, whichever is earlier.

Sec. 33. Minnesota Statutes 2024, section 144E.123, subdivision 3, is amended to read:

Subd. 3. **Review.** Prehospital care data may be reviewed by the director or its designees. The data shall be classified as private data on individuals under chapter 13, the Minnesota Government Data Practices Act. The director may share with the Washington/Baltimore High Intensity Drug Trafficking Area's Overdose Detection Mapping Application Program (ODMAP) data that identifies where and when an overdose incident happens, fatality status, suspected drug type, naloxone administration, and first responder type. ODMAP may:

(1) allow secure access to the system by authorized users to report information about an overdose incident;

(2) allow secure access to the system by authorized users to view, in near real time, information about overdose incidents reported;

(3) produce a map in near real time of the approximate locations of confirmed or suspected overdose incidents reported; and

(4) enable access to overdose incident information that assists in state and local decisions regarding the allocation of public health, public safety, and educational resources for the purposes of monitoring and reporting data related to suspected overdoses.

Sec. 34. **[144E.54] AMBULANCE OPERATING DEFICIT GRANT PROGRAM.**

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

(b) "Capital expenses" means expenses incurred by a licensee for the purchase, improvement, or maintenance of assets with an expected useful life of greater than five years that improve the efficiency of provided ambulance services or the capabilities of the licensee.

(c) "Eligible applicant" or "eligible licensee" means any licensee who possessed a license not excluded under subdivision 4 or 5 in the last completed state fiscal year for which data was provided to the director, as provided in section 62J.49; who continues to operate that same nonexcluded license at the time of application; and who provides verifiable evidence of an operating deficit in the state fiscal year prior to submitting an application.

(d) "Government licensee" means any government entity, as defined in section 118A.01, subdivision 2, including a Tribe, that is a licensee.

(e) "Insurance revenue" means revenue from Medicare, medical assistance, private health insurance, third-party liability insurance, and payments from individuals.

(f) "Operating deficit" means the sum of insurance revenue and other revenue is less than the sum of operational expenses and capital expenses.

(g) "Operational expenses" means costs related to the day-to-day operations of an ambulance service, including but not limited to costs related to personnel, supplies and equipment, fuel, vehicle maintenance, travel, education, and fundraising.

(h) "Other revenue" means revenue from any revenue that is not insurance revenue, including but not limited to grants, tax revenue, donations, fundraisers, or standby fees. Grants awarded under this section must not be considered revenue.

Subd. 2. **Program establishment.** An ambulance operating deficit grant program is established to award grants to applicants to address revenue shortfalls creating operating deficits among eligible applicants.

Subd. 3. **Account established.** An ambulance operating deficit account is created in the special revenue fund in the state treasury. The director shall credit the account appropriations and transfers to the account. Earnings, including interest, dividends, and any other earnings arising from assets of the account, must be credited to the account. The director shall manage the account.

Subd. 4. **Licensees providing specialized life support services excluded.** Licensees providing specialized life support services as described in section 144E.101, subdivision 9, are not eligible for grants under this section.

Subd. 5. **Other licensees excluded.** Licensees whose individual primary service areas are located mostly within a metropolitan county listed in section 473.121, subdivision 4, or within the cities of Duluth, Mankato, St. Cloud, or Rochester are not eligible for grants under this section.

Subd. 6. **Application process.** (a) An eligible licensee may apply to the director, in the form and manner determined by the director, for a grant under this section.

(b) A grant application made by a government licensee must be accompanied by a resolution of support from the governing body.

Subd. 7. **Director calculations.** The director shall award grants only to applicants who provide verifiable evidence of an operating deficit in the last completed state fiscal year for which data were provided to the director. The director may audit the financial data provided to the director by applicants, as provided in section 62J.49. A grant awarded must not be more than five percent more than any previous grant without special permission from the director.

Subd. 8. **Grant awards; limitations.** (a) Grants awarded under this section to eligible applicants may be proportionally distributed based on money available. Total amounts awarded must not exceed the amount in the ambulance operating deficit account.

(b) The director shall award grants annually.

(c) The director must not award individual grants that exceed the amount of the grantee's most recent verified operating deficit as reported to the director.

Subd. 9. **Eligible expenditures.** A grantee must spend grant money received under this section on operational expenses and capital expenses incurred to provide ambulance services.

Subd. 10. **Report.** By February 15, 2026, and annually thereafter, the director must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy. The report must describe the number and amount of grants awarded under this section and the uses made of grant money by grantees.

Sec. 35. **[145.076] INFORMED CONSENT REQUIRED FOR SENSITIVE EXAMINATIONS.**

Subdivision 1. **Definition.** For purposes of this section, "sensitive examination" means a pelvic, breast, urogenital, or rectal examination.

Subd. 2. **Informed consent required; exceptions.** A health professional, or a student or resident participating in a course of instruction, clinical training, or a residency program for a health profession, shall not perform a sensitive examination on an anesthetized or unconscious patient unless:

(1) the patient or the patient's legally authorized representative provided prior, written, informed consent to the sensitive examination and the sensitive examination is necessary for preventive, diagnostic, or treatment purposes;

(2) the patient or the patient's legally authorized representative provided prior, written, informed consent to a surgical procedure or diagnostic examination and the sensitive examination is within the scope of care ordered for that surgical procedure or diagnostic examination;

(3) the patient is unconscious and incapable of providing informed consent and the sensitive examination is necessary for diagnostic or treatment purposes; or

(4) a court ordered a sensitive examination to be performed for purposes of collection of evidence.

Subd. 3. **Penalty; ground for disciplinary action.** A person who violates this section is subject to disciplinary action by the health-related licensing board regulating the person.

Sec. 36. Minnesota Statutes 2024, section 145.8811, is amended to read:

145.8811 MATERNAL AND CHILD HEALTH ADVISORY ~~TASK FORCE~~ COMMITTEE.

Subdivision 1. **Composition of ~~task force~~ committee.** The commissioner shall establish and appoint a Maternal and Child Health Advisory ~~Task Force~~ Committee consisting of 15 members who will provide equal representation from:

(1) professionals with expertise in maternal and child health services;

(2) representatives of community health boards as defined in section 145A.02, subdivision 5; and

(3) consumer representatives interested in the health of mothers and children.

No members shall be employees of the Minnesota Department of Health. Section 15.059 governs the Maternal and Child Health Advisory ~~Task Force~~ Committee. Notwithstanding section 15.059, the Maternal and Child Health Advisory ~~Task Force~~ Committee does not expire.

Subd. 2. **Duties.** The advisory ~~task force~~ committee shall meet on a regular basis to perform the following duties:

(1) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(2) review and report on the type, frequency, and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(3) establish, review, and report to the commissioner a list of program guidelines and criteria ~~which~~ the advisory ~~task force~~ committee considers essential to providing an effective maternal and child health care program to low-income populations and high-risk persons and fulfilling the purposes defined in section 145.88;

(4) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

(5) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services:

(i) prenatal, delivery, and postpartum care;

(ii) comprehensive health care for children, especially from birth through five years of age;

(iii) adolescent health services;

(iv) family planning services;

(v) preventive dental care;

(vi) special services for chronically ill and disabled children; and

(vii) any other services that promote the health of mothers and children; and

(6) establish in consultation with the commissioner statewide outcomes that will improve the health status of mothers and children.

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

Sec. 37. Minnesota Statutes 2024, section 145.901, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** Within the limits of available funding, the commissioner of health ~~may~~ must conduct maternal death studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable maternal deaths in Minnesota.

Sec. 38. Minnesota Statutes 2024, section 145.987, subdivision 1, is amended to read:

Subdivision 1. **Establishment; composition of advisory council.** The health equity advisory and leadership (HEAL) council consists of 18 members appointed by the commissioner of health, including but not limited to members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Sec. 39. Minnesota Statutes 2024, section 145.987, subdivision 2, is amended to read:

Subd. 2. **Organization and meetings.** (a) Terms, compensation, and removal of members of the advisory council shall be as provided in section 15.059, subdivisions 2 to 4, except that terms for advisory council members shall be for two years. Members may be reappointed to serve up to two additional terms. Notwithstanding section 15.059, subdivision 6, the advisory council shall not expire. ~~The commissioner shall recommend appointments to replace members vacating their positions in a timely manner, no more than three months after the advisory council reviews panel recommendations.~~

(b) The commissioner must convene meetings at least quarterly and must provide meeting space and administrative support to the advisory council. Subcommittees may be convened

as necessary. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Sec. 40. **[148.781] CENTRAL SERVICE TECHNICIAN.**

Subdivision 1. **Application.** This section applies to persons who perform the functions of a central service technician in a health care facility.

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

(1) "central service technician" means a person who decontaminates, inspects, assembles, packages, and sterilizes reusable medical instruments or devices used by a health care facility;

(2) "health care facility" means a hospital or ambulatory surgical center; and

(3) "health care practitioner" means an individual regulated by a health-related licensing board as defined in section 214.01, subdivision 2, or by the commissioner of health under sections 148.511 to 148.5198, to the extent the individual provides services in a health care facility and the tasks of a central service technician are within the individual's scope of practice. Health care practitioner includes an intern, resident, or fellow who performs or assists with surgery.

Subd. 3. **Requirements for central service technician.** (a) A health care facility shall employ or otherwise retain the services of a central service technician only if the central service technician:

(1) has successfully passed a nationally accredited examination for central service technicians and holds and maintains one of the following credentials administered by a nationally accredited central service technician credentialing organization: a certified registered central service technician credential, a certified endoscope reprocessor credential, a certified sterile processing and distribution technician credential, or a certified flexible endoscope reprocessor credential; or

(2) provides evidence that the person was employed by or was retained as a central service technician by a health care facility on or before December 31, 2027.

(b) A central service technician who does not meet the requirements of paragraph (a), clause (1), shall have 24 months from the date of hire to obtain a certified registered central service technician credential, a certified endoscope reprocessor credential, a certified sterile

processing and distribution technician credential, or a certified flexible endoscope reprocessor credential.

(c) A person who qualifies to operate as a central service technician in a health care facility under paragraph (a) must annually complete ten hours of continuing education credits to remain qualified to operate as a central service technician. The continuing education required under this paragraph must be related to the functions of a central service technician.

(d) Nothing in this subdivision shall prohibit the following persons from performing the tasks or functions of a central service technician:

(1) a health care practitioner;

(2) a person who holds or maintains a registration, certification, or license by a nationally accredited credentialing organization to perform health care services; or

(3) a student or intern performing the functions of a central service technician under the direct supervision of a health care practitioner as part of the student's or intern's training or internship.

(e) A health care facility shall, upon the written request of a central service technician, verify in writing the central service technician's dates of employment or the contract period during which the central service technician provided services to the health care facility.

EFFECTIVE DATE. This section is effective 180 days after final enactment.

Sec. 41. **TRANSFER OF PROGRAM.**

The healthy eating, here at home program is transferred from the Minnesota Humanities Center to the Department of Health on July 1, 2025. The provisions of Minnesota Statutes, section 15.039, apply to this transfer.

Sec. 42. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 138.912, as section 144.0554. The revisor shall make any cross-reference changes necessary resulting from the renumbering of the healthy eating, here at home program.

Sec. 43. **REPEALER.**

Minnesota Statutes 2024, sections 62K.10, subdivision 3; and 138.912, subdivision 7, are repealed.

ARTICLE 3
HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2024, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 147.037, subdivision 1b, paragraph (d); 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

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

Sec. 2. Minnesota Statutes 2024, section 144A.43, subdivision 15, is amended to read:

Subd. 15. **Occupational therapist.** "Occupational therapist" ~~means a person who is licensed under sections 148.6401 to 148.6449~~ has the meaning given in section 148.6402, subdivision 14.

Sec. 3. Minnesota Statutes 2024, section 144G.08, subdivision 45, is amended to read:

Subd. 45. **Occupational therapist.** "Occupational therapist" ~~means a person who is licensed under sections 148.6401 to 148.6449~~ has the meaning given in section 148.6402, subdivision 14.

Sec. 4. Minnesota Statutes 2024, section 147.01, subdivision 7, is amended to read:

Subd. 7. **Physician application and license fees.** (a) The board may charge the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee, $200;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

(5) physician late fee, $60;

(6) nonrenewable 24-month limited license, $392;

(7) initial physician license for limited license holder, $192;

~~(6)~~ (8) duplicate license fee, $20;

~~(7)~~ (9) certification letter fee, $25;

~~(8)~~ (10) education or training program approval fee, $100;

~~(9)~~ (11) report creation and generation fee, $60 per hour;

~~(10)~~ (12) examination administration fee (half day), $50;

~~(11)~~ (13) examination administration fee (full day), $80;

~~(12)~~ (14) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000; and

~~(13)~~ (15) verification fee, $25.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

Sec. 5. Minnesota Statutes 2024, section 147.037, is amended by adding a subdivision to read:

Subd. 1b. **Limited license.** (a) A limited license under this section is valid for one 24-month period and is not renewable or eligible for reapplication. The board may issue a limited license, valid for 24 months, to any person who satisfies the requirements of subdivision 1, paragraphs (a) to (c) and (e) to (g), and who:

(1) pursuant to a license or other authorization to practice, has practiced medicine, as defined in section 147.081, subdivision 3, clauses (2) to (4), for at least 60 months in the previous 12 years outside of the United States;

(2) submits sufficient evidence of an offer to practice within the context of a collaborative agreement within a hospital or clinical setting where the limited license holder and physicians work together to provide patient care;

(3) provides services in a designated rural area or underserved urban community as defined in section 144.1501; and

(4) submits two letters of recommendation in support of a limited license, which must include one letter from a physician with whom the applicant previously worked and one letter from an administrator of the hospital or clinical setting in which the applicant previously worked. The letters of recommendation must attest to the applicant's good medical standing. The board may accept alternative forms of proof that demonstrate good medical standing where there are extenuating circumstances that prevent an applicant from providing letters.

(b) For purposes of this subdivision, a person has satisfied the requirements of subdivision 1, paragraph (e), if the person has passed steps or levels one and two of the USMLE or the COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts.

(c) A person issued a limited license under this subdivision must not be required to present evidence satisfactory to the board of the completion of one year of graduate clinical medical training in a program accredited by a national accrediting organization approved by the board.

(d) An employer of a limited license holder must pay the limited license holder at least an amount equivalent to a medical resident in a comparable field. The employer must carry medical malpractice insurance covering a limited license holder for the duration of the employment. The commissioner of health may issue a correction order under section 144.99, subdivision 3, requiring an employer to comply with this paragraph. An employer must not retaliate against or discipline an employee for raising a complaint or pursuing enforcement relating to this paragraph.

(e) The board may issue a full and unrestricted license to practice medicine to a person who holds a limited license issued pursuant to paragraph (a) and who has:

(1) held the limited license for two years and is in good standing to practice medicine in Minnesota;

(2) practiced for a minimum of 1,692 hours per year for each of the previous two years;

(3) submitted a letter of recommendation in support of a full and unrestricted license containing all attestations required under paragraph (i) from any physician who participated in the collaborative agreement;

(4) passed steps or levels one, two, and three of the USMLE or COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts; and

(5) completed 20 hours of continuing medical education.

(f) A limited license holder must submit to the board, every six months or upon request, a statement certifying whether the person is still employed as a physician in Minnesota and whether the person has been subjected to professional discipline as a result of the person's practice. The board may suspend or revoke a limited license if a majority of the board determines that the licensee is no longer employed as a physician in Minnesota by an employer. The licensee must be granted an opportunity to be heard prior to the board's determination. Upon request by the limited license holder, the limited license holder may have 90 days to regain employment. A licensee may change employers during the duration of the limited license if the licensee has another offer of employment. In the event that a change of employment occurs, the licensee must still work the number of hours required under paragraph (e), clause (2), to be eligible for a full and unrestricted license to practice medicine.

(g) In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a limited license holder if the board finds that the limited license holder has violated a statute or rule that the board is empowered to enforce and continued practice by the limited license holder would create a serious risk of harm to the public. The suspension shall take effect upon written notice to the limited license holder specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The limited license holder shall be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

(h) For purposes of this subdivision, "collaborative agreement" means a mutually agreed upon plan for the overall working relationship and collaborative arrangement between a holder of a limited license and one or more physicians licensed under this chapter that designates the scope of services that can be provided to manage the care of patients. The limited license holder and one of the collaborating physicians must have experience in providing care to patients with the same or similar medical conditions. Under the collaborative agreement, the limited license holder must shadow the collaborating physician for four weeks, after which time the limited license holder must staff all patient encounters with the collaborating physician for an additional four weeks. After that time, the collaborating physician has discretion to allow the limited license holder to see patients independently and will require the limited license holder to present patients at their discretion. However, the limited license holder must be supervised by the collaborating physician for

a minimum of two hours per week. A limited license holder may practice medicine without a collaborating physician physically present, but the limited license holder and collaborating physicians must be able to easily contact each other by radio, telephone, or other telecommunication device while the limited license holder practices medicine. The limited license holder must have one-on-one practice reviews with each collaborating physician, provided in person or through eye-to-eye electronic media while maintaining visual contact, for at least two hours per week.

(i) At least one collaborating physician must submit a letter to the board, after the limited license holder has practiced under the license for 12 months, attesting that:

(1) the limited license holder has a basic understanding of federal and state laws regarding the provision of health care, including but not limited to:

(i) medical licensing obligations and standards; and

(ii) the Health Insurance Portability and Accountability Act, Public Law 104-191;

(2) the limited license holder has a basic understanding of documentation standards;

(3) the limited license holder has a thorough understanding of which medications are available and unavailable in the United States;

(4) the limited license holder has a thorough understanding of American medical standards of care;

(5) the limited license holder has demonstrated mastery of each of the following:

(i) gathering a history and performing a physical exam;

(ii) developing and prioritizing a differential diagnosis following a clinical encounter and selecting a working diagnosis;

(iii) recommending and interpreting common diagnostic and screening tests;

(iv) entering and discussing orders and prescriptions;

(v) providing an oral presentation of a clinical encounter;

(vi) giving a patient handover to transition care responsibly;

(vii) recognizing a patient requiring urgent care and initiating an evaluation; and

(viii) obtaining informed consent for tests, procedures, and treatments; and

(6) the limited license holder is providing appropriate medical care.

(j) The board must not grant a license under this section unless the applicant possesses federal immigration status that allows the applicant to practice as a physician in the United States.

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

Sec. 6. Minnesota Statutes 2024, section 147A.02, is amended to read:

147A.02 QUALIFICATIONS FOR LICENSURE.

(a) The board may grant a license as a physician assistant to an applicant who:

(1) submits an application on forms approved by the board;

(2) pays the appropriate fee as determined by the board;

(3) has current certification from the National Commission on Certification of Physician Assistants, or its successor agency as approved by the board;

(4) certifies that the applicant is mentally and physically able to engage safely in practice as a physician assistant;

(5) has no licensure, certification, or registration as a physician assistant under current discipline, revocation, suspension, or probation for cause resulting from the applicant's practice as a physician assistant, unless the board considers the condition and agrees to licensure;

(6) submits any other information the board deems necessary to evaluate the applicant's qualifications; and

(7) has been approved by the board.

(b) All persons registered as physician assistants as of June 30, 1995, are eligible for continuing license renewal. All persons applying for licensure after that date shall be licensed according to this chapter.

(c) A physician assistant who qualifies for licensure must practice for at least 2,080 hours, within the context of a collaborative agreement, within a hospital or integrated clinical setting where physician assistants and physicians work together to provide patient care. The physician assistant shall submit written evidence to the board with the application, or upon completion of the required collaborative practice experience. For purposes of this paragraph, a collaborative agreement is a mutually agreed upon plan for the overall working relationship ~~and collaborative arrangement~~ between a physician assistant~~,~~ and one or more physicians licensed under chapter 147 or licensed in another state or United States territory, that

designates the scope of ~~services that can be provided~~ collaboration necessary to manage the care of patients. The physician assistant and one of the collaborative physicians must have experience in providing care to patients with the same or similar medical conditions. The collaborating physician is not required to be physically present so long as the collaborating physician and physician assistant are or can be easily in contact with each other by radio, telephone, or other telecommunication device.

Sec. 7. Minnesota Statutes 2024, section 147D.03, subdivision 1, is amended to read:

Subdivision 1. **General.** Within the meaning of sections 147D.01 to 147D.27, a person who shall publicly profess to be a traditional midwife and who, for a fee, shall assist or attend to a woman in pregnancy, childbirth outside a hospital, and postpartum, shall be regarded as practicing traditional midwifery. A certified midwife licensed by the Board of Nursing under chapter 148G is not subject to the provisions of this chapter.

Sec. 8. Minnesota Statutes 2024, section 148.108, subdivision 1, is amended to read:

Subdivision 1. **Fees.** ~~In addition to the fees established in Minnesota Rules, chapter 2500,~~ The board is authorized to charge the fees in this section.

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

Sec. 9. Minnesota Statutes 2024, section 148.108, is amended by adding a subdivision to read:

Subd. 5. **Chiropractic license fees.** Fees for chiropractic licensure must not exceed the following amounts but may be adjusted lower by board action:

(1) initial application for licensure fee, $600;

(2) annual renewal of an active license fee, $250;

(3) annual renewal of an inactive license fee, 75 percent of the current active license renewal fee under clause (2);

(4) late renewal penalty fee, $150 per month late; and

(5) application for reinstatement of a voluntarily retired or inactive license fee, $100.

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

Sec. 10. Minnesota Statutes 2024, section 148.108, is amended by adding a subdivision to read:

Subd. 6. **Acupuncture registration fees.** Fees for acupuncture registration must not exceed the following amounts but may be adjusted lower by board action:

(1) initial application acupuncture registration fee, $400;

(2) annual renewal of active acupuncture registration fee, $200;

(3) annual renewal of inactive acupuncture registration fee, 75 percent of the current active acupuncture registration renewal fee under clause (2); and

(4) reinstatement of nonrenewed acupuncture registration fee, $400.

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

Sec. 11. Minnesota Statutes 2024, section 148.108, is amended by adding a subdivision to read:

Subd. 7. **Independent examiner registration fees.** Fees for independent examiner registration must not exceed the following amounts but may be adjusted lower by board action:

(1) initial application independent examiner registration fee, $400;

(2) annual renewal of independent examiner registration fee, $200; and

(3) reinstatement of nonrenewed independent examiner registration fee, $400.

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

Sec. 12. Minnesota Statutes 2024, section 148.108, is amended by adding a subdivision to read:

Subd. 8. **Animal chiropractic registration fees.** Fees for animal chiropractic registration must not exceed the following amounts but may be adjusted lower by board action:

(1) initial application animal chiropractic registration fee, $400;

(2) annual renewal of active animal chiropractic registration fee, $200;

(3) annual renewal of inactive animal chiropractic registration fee, 75 percent of the current active animal chiropractic renewal fee under clause (2); and

(4) reinstatement of nonrenewed animal chiropractic registration fee, $400.

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

Sec. 13. Minnesota Statutes 2024, section 148.108, is amended by adding a subdivision to read:

Subd. 9. **Graduate preceptorship registration fee.** The application fee for graduate preceptorship registration is an amount not to exceed $500, but may be adjusted lower by board action.

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

Sec. 14. Minnesota Statutes 2024, section 148.108, is amended by adding a subdivision to read:

Subd. 10. **Professional firm registration fees.** In addition to fees authorized under chapter 319B, the late renewal penalty fee for professional firm registration is $5 per month late.

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

Sec. 15. Minnesota Statutes 2024, section 148.108, is amended by adding a subdivision to read:

Subd. 11. **Miscellaneous fees.** Fees under this subdivision must not exceed the following amounts but may be adjusted lower by board action:

(1) annual continuing education sponsorship fee, $1,000;

(2) individual continuing education seminar sponsorship fee, $400;

(3) mailing list request fee, $500;

(4) license verification fee, $50;

(5) duplicate certificate fee, $50; and

(6) document copies fee, $0.25 per side of document page.

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

Sec. 16. Minnesota Statutes 2024, section 148.191, subdivision 2, is amended to read:

Subd. 2. **Powers.** (a) The board is authorized to adopt and, from time to time, revise rules not inconsistent with the law, as may be necessary to enable it to carry into effect the provisions of sections 148.171 to 148.285 and chapter 148G. The board shall prescribe by rule curricula and standards for schools and courses preparing persons for licensure under sections 148.171 to 148.285 and 148G.12. It shall conduct or provide for surveys of such

schools and courses at such times as it may deem necessary. It shall approve such schools and courses as meet the requirements of sections 148.171 to 148.285 or section 148G.12, and board rules. It shall examine, license, and renew the license of duly qualified applicants. It shall hold examinations at least once in each year at such time and place as it may determine. It shall by rule adopt, evaluate, and periodically revise, as necessary, requirements for licensure and for registration and renewal of registration as defined in section 148.231 and chapter 148G. It shall maintain a record of all persons licensed by the board to practice advanced practice, professional, or practical nursing, or certified as a midwife. It shall cause the prosecution of all persons violating sections 148.171 to 148.285 or chapter 148G, and have power to incur such necessary expense therefor. It shall register public health nurses who meet educational and other requirements established by the board by rule, including payment of a fee. It shall have power to issue subpoenas, and to compel the attendance of witnesses and the production of all necessary documents and other evidentiary material. Any board member may administer oaths to witnesses, or take their affirmation. It shall keep a record of all its proceedings.

(b) The board shall have access to hospital, nursing home, and other medical records of a patient cared for by a nurse or certified midwife under review. If the board does not have a written consent from a patient permitting access to the patient's records, the nurse, certified midwife, or facility shall delete any data in the record that identifies the patient before providing it to the board. The board shall have access to such other records as reasonably requested by the board to assist the board in its investigation. Nothing herein may be construed to allow access to any records protected by section 145.64. The board shall maintain any records obtained pursuant to this paragraph as investigative data under chapter 13.

(c) The board may accept and expend grants or gifts of money or in-kind services from a person, a public or private entity, or any other source for purposes consistent with the board's role and within the scope of its statutory authority.

(d) The board may accept registration fees for meetings and conferences conducted for the purposes of board activities that are within the scope of its authority.

Sec. 17. Minnesota Statutes 2024, section 148.241, is amended to read:

148.241 EXPENSES.

Subdivision 1. **Appropriation.** The expenses of administering sections 148.171 to 148.285 and chapter 148G shall be paid from the appropriation made to the Minnesota Board of Nursing.

Subd. 2. **Expenditure.** All amounts appropriated to the board shall be held subject to the order of the board to be used only for the purpose of meeting necessary expenses incurred in the performance of the purposes of sections 148.171 to 148.285 and chapter 148G, and the duties imposed thereby as well as the promotion of nursing or certified midwifery education and standards of nursing or certified midwifery care in this state.

Sec. 18. Minnesota Statutes 2024, section 148.512, subdivision 17a, is amended to read:

Subd. 17a. **Speech-language pathology assistant.** "Speech-language pathology assistant" means a person who meets the qualifications under section 148.5181 and provides speech-language pathology services under the supervision of a licensed speech-language pathologist under sections 122A.183 and 122A.184 or in accordance with section 148.5192.

Sec. 19. Minnesota Statutes 2024, section 148.5192, subdivision 3, is amended to read:

Subd. 3. **Supervision requirements.** (a) A supervising speech-language pathologist shall authorize and accept full responsibility for the performance, practice, and activity of a speech-language pathology assistant. The amount and type of supervision required must be based on the skills and experience of the speech-language pathology assistant. A minimum of one hour every 30 days of consultative supervision time must be documented for each speech-language pathology assistant.

(b) A supervising speech-language pathologist must:

(1) be licensed under sections 122A.183, 122A.184, or 148.511 to 148.5198;

(2) hold a certificate of clinical competence from the American Speech-Language-Hearing Association or its equivalent as approved by the commissioner; and

(3) have completed at least ten hours of continuing education in supervision.

(c) Once every 60 days, the supervising speech-language pathologist must treat or cotreat with the speech-language pathology assistant each client on the speech-language pathology assistant's caseload.

(d) For purposes of this section, "direct supervision" means observation and guidance by the supervising speech-language pathologist during the performance of a delegated duty that occurs either on-site and in-view or through the use of real-time, two-way interactive audio and visual communication. The supervision requirements described in this section are minimum requirements. Additional supervision requirements may be imposed at the discretion of the supervising speech-language pathologist.

(e) A supervising speech-language pathologist must be available to communicate with a speech-language pathology assistant at any time the assistant is in direct contact with a client.

(f) A supervising speech-language pathologist must document activities performed by the assistant that are directly supervised by the supervising speech-language pathologist. At a minimum, the documentation must include:

(1) information regarding the quality of the speech-language pathology assistant's performance of the delegated duties; and

(2) verification that any delegated clinical activity was limited to duties authorized to be performed by the speech-language pathology assistant under this section.

(g) A supervising speech-language pathologist must review and cosign all informal treatment notes signed or initialed by the speech-language pathology assistant.

(h) A full-time, speech-language pathologist may supervise no more than two full-time, speech-language pathology assistants or the equivalent of two full-time assistants.

Sec. 20. Minnesota Statutes 2024, section 148.5194, subdivision 3b, is amended to read:

Subd. 3b. **Speech-language pathology assistant licensure fees.** The fee for initial licensure as a speech-language pathology assistant ~~is $493~~ must not exceed $220. The fee for licensure renewal for a speech-language pathology assistant ~~is $493~~ must not exceed $220.

Sec. 21. Minnesota Statutes 2024, section 148.56, subdivision 1, is amended to read:

Subdivision 1. **Optometry defined.** (a) Any person shall be deemed to be practicing optometry within the meaning of sections 148.52 to 148.62 who shall in any way:

(1) advertise as an optometrist;

(2) employ any means, including the use of autorefractors or other automated testing devices, for the measurement of the powers of vision or the adaptation of lenses or prisms for the aid thereof;

(3) possess testing appliances for the purpose of the measurement of the powers of vision;

(4) diagnose any disease, optical deficiency or deformity, or visual or muscular anomaly of the visual system consisting of the human eye and its accessory or subordinate anatomical parts;

(5) prescribe lenses, including plano or cosmetic contact lenses, or prisms for the correction or the relief of same;

(6) employ or prescribe ocular exercises, orthoptics, or habilitative and rehabilitative therapeutic vision care; or

(7) prescribe or administer legend drugs to aid in the diagnosis, cure, mitigation, prevention, treatment, or management of disease, deficiency, deformity, or abnormality of the human eye and adnexa included in the curricula of accredited schools or colleges of optometry, and as limited by Minnesota statute and adopted rules by the Board of Optometry, or who holds oneself out as being able to do so.

(b) In the course of treatment, nothing in this section shall allow:

(1) legend drugs to be administered intravenously~~, intramuscularly, or by injection, except for treatment of anaphylaxis~~ or by sub-Tenon, retrobulbar, or intravitreal injection;

(2) invasive surgery including, but not limited to, surgery using lasers;

(3) Schedule II and III oral legend drugs ~~and oral steroids~~ to be administered or prescribed; or

(4) oral ~~antivirals to be prescribed or administered for more than ten days; or~~ steroids to be administered or prescribed for more than 14 days without consultation with a physician.

~~(5) oral carbonic anhydrase inhibitors to be prescribed or administered for more than seven days.~~

Sec. 22. Minnesota Statutes 2024, section 148.6401, is amended to read:

148.6401 SCOPE.

Sections 148.6401 to ~~148.6449~~ 148.645 apply to persons who are applicants for licensure, who are licensed, who use protected titles, or who represent that they are licensed as ~~occupational therapists or~~ occupational therapy ~~assistants~~ practitioners.

Sec. 23. Minnesota Statutes 2024, section 148.6402, subdivision 1, is amended to read:

Subdivision 1. **Scope.** For the purpose of sections 148.6401 to ~~148.6449~~ 148.645, the following terms have the meanings given them.

Sec. 24. Minnesota Statutes 2024, section 148.6402, is amended by adding a subdivision to read:

Subd. 2a. **Accreditation Council for Occupational Therapy Education or ACOTE.** "Accreditation Council for Occupational Therapy Education" or "ACOTE" means the entity that accredits occupational therapy education programs in the United States and its territories and establishes, approves, and administers educational standards ensuring consistency across all occupational therapy education.

Sec. 25. Minnesota Statutes 2024, section 148.6402, is amended by adding a subdivision to read:

Subd. 5a. **Continuing competence.** "Continuing competence" means the process in which an occupational therapy practitioner develops and maintains the knowledge, critical reasoning, interpersonal skills, performance skills, and ethical practice necessary to perform their occupational therapy responsibilities.

Sec. 26. Minnesota Statutes 2024, section 148.6402, subdivision 7, is amended to read:

Subd. 7. **~~Credentialing~~ Certification examination for occupational therapist.** "~~Credentialing~~ Certification examination for occupational therapist" means the examination sponsored by the National Board for Certification in Occupational Therapy for ~~credentialing~~ certification as ~~an~~ a registered occupational therapist~~, registered~~.

Sec. 27. Minnesota Statutes 2024, section 148.6402, subdivision 8, is amended to read:

Subd. 8. **~~Credentialing~~ Certification examination for occupational therapy assistant.** "~~Credentialing~~ Certification examination for occupational therapy assistant" means the examination sponsored by the National Board for Certification in Occupational Therapy for ~~credentialing~~ certification as a certified occupational therapy assistant.

Sec. 28. Minnesota Statutes 2024, section 148.6402, is amended by adding a subdivision to read:

Subd. 12a. **Face-to-face supervision.** "Face-to-face supervision" means supervision occurring between a supervisor and a supervisee within each other's sight or presence. Face-to-face supervision includes real-time audio and video communication where the supervisor and supervisee can see each other and clearly visualize the services being provided.

Sec. 29. Minnesota Statutes 2024, section 148.6402, subdivision 13, is amended to read:

Subd. 13. **Licensed health care professional.** "Licensed health care professional" means a person licensed in good standing in Minnesota to practice medicine, osteopathic medicine, chiropractic, podiatry, advanced practice registered nursing, ~~or~~ dentistry, or ~~is a person registered~~ as a licensed physician assistant in Minnesota.

Sec. 30. Minnesota Statutes 2024, section 148.6402, is amended by adding a subdivision to read:

Subd. 13a. **National Board for Certification in Occupational Therapy or NBCOT.** "National Board for Certification in Occupational Therapy" or "NBCOT" means the entity that administers the certification examination and provides initial and renewal board certification for occupational therapy practitioners providing services in the United States, or any successor entity performing the certification examination and initial and renewal board certification.

Sec. 31. Minnesota Statutes 2024, section 148.6402, subdivision 14, is amended to read:

Subd. 14. **Occupational therapist.** "Occupational therapist" means an individual ~~who meets the qualifications in sections 148.6401 to 148.6449 and is licensed by the board~~ licensed to practice occupational therapy under sections 148.6401 to 148.645 who is responsible for and directs the evaluation process, discharge planning process, development of intervention plans, and provision of occupational therapy services.

Sec. 32. Minnesota Statutes 2024, section 148.6402, subdivision 16, is amended to read:

Subd. 16. **Occupational therapy assistant.** "Occupational therapy assistant" means an individual ~~who meets the qualifications for an occupational therapy assistant in sections 148.6401 to 148.6449 and is licensed by the board~~ licensed to assist in the practice of occupational therapy under sections 148.6401 to 148.645 who works under the appropriate supervision of and in partnership with an occupational therapist, unless exempted under section 148.6432.

Sec. 33. Minnesota Statutes 2024, section 148.6402, subdivision 16a, is amended to read:

Subd. 16a. **Occupational therapy practitioner.** "Occupational therapy practitioner" means any individual licensed as either an occupational therapist or occupational therapy assistant under sections 148.6401 to ~~148.6449~~ 148.645.

Sec. 34. Minnesota Statutes 2024, section 148.6402, subdivision 19, is amended to read:

Subd. 19. **License or licensed.** "License" or "licensed" means the act or status of a natural person who meets the requirements of sections 148.6401 to ~~148.6449~~ 148.645.

Sec. 35. Minnesota Statutes 2024, section 148.6402, subdivision 20, is amended to read:

Subd. 20. **Licensee.** "Licensee" means a person who meets the requirements of sections 148.6401 to ~~148.6449~~ 148.645.

Sec. 36. Minnesota Statutes 2024, section 148.6402, subdivision 23, is amended to read:

Subd. 23. **Service competency.** (a) "Service competency" of an occupational therapy assistant in performing evaluation tasks means the ability of an occupational therapy assistant to obtain the same information as the supervising occupational therapist when evaluating a client's function.

(b) "Service competency" of an occupational therapy assistant in performing treatment procedures means the ability of an occupational therapy assistant to perform treatment procedures in a manner such that the outcome, documentation, and follow-up are equivalent to that which would have been achieved had the supervising occupational therapist performed the treatment procedure.

(c) "Service competency" of an occupational therapist means the ability of an occupational therapist to consistently perform an assessment task or intervention procedure with the level of skill recognized as satisfactory within the ~~appropriate acceptable prevailing practice~~ national practice standards of occupational therapy.

Sec. 37. Minnesota Statutes 2024, section 148.6402, subdivision 25, is amended to read:

Subd. 25. **Temporary licensure.** "Temporary licensure" means a method of licensure described in section 148.6418, by which an individual who (1) has completed an approved or accredited education program but has not met the examination requirement; or (2) possesses a credential from another jurisdiction or the National Board for Certification in Occupational Therapy but who has not submitted the documentation required by section 148.6420~~, subdivisions 3 and 4,~~ may qualify for Minnesota licensure for a limited time period.

Sec. 38. Minnesota Statutes 2024, section 148.6403, is amended to read:

148.6403 LICENSURE; PROTECTED TITLES AND RESTRICTIONS ON USE; EXEMPT PERSONS; SANCTIONS.

Subdivision 1. **Unlicensed practice prohibited.** A person must not engage in the practice of occupational therapy unless the person is licensed as an occupational therapy practitioner in accordance with sections 148.6401 to ~~148.6449~~ 148.645.

Subd. 2. **Protected titles and restrictions on use.** Use of the phrase "occupational therapy," ~~or~~ "occupational therapist," or "occupational therapy assistant," or the initials "OT" or "OTA" alone or in combination with any other words or initials to form an occupational title, or to indicate or imply that the person is licensed by the state as an occupational therapist or occupational therapy assistant, is prohibited unless that person is licensed under sections 148.6401 to ~~148.6449~~ 148.645.

Subd. 3. **Use of "Minnesota licensed."** Use of the term "Minnesota licensed" in conjunction with titles protected under this section by any person is prohibited unless that person is licensed under sections 148.6401 to ~~148.6449~~ 148.645.

Subd. 4. **Persons licensed or certified in other states.** A person who is licensed in Minnesota and licensed or certified in another ~~state~~ jurisdiction may use the designation "licensed" or "certified" with a protected title only if the ~~state~~ jurisdiction of licensure or certification is clearly indicated.

Subd. 5. **Exempt persons.** This section does not apply to:

(1) a person employed as an occupational therapy practitioner by the government of the United States or any agency of it. However, use of the protected titles under those circumstances is allowed only in connection with performance of official duties for the federal government;

(2) a student participating in supervised fieldwork or supervised coursework that is necessary to meet the requirements of section 148.6408, subdivision 1, or 148.6410, subdivision 1, if the person is designated by a title which clearly indicates the person's status as a student trainee. Any use of the protected titles under these circumstances is allowed only while the person is performing the duties of the supervised fieldwork or supervised coursework; ~~or~~

~~(3) a person visiting and then leaving the state and performing occupational therapy services while in the state, if the services are performed no more than 30 days in a calendar~~

~~year as part of a professional activity that is limited in scope and duration and is in association with an occupational therapist licensed under sections 148.6401 to 148.6449, and~~

~~(i) the~~ (3) a person who is credentialed under the law of another state ~~which~~ that has credentialing requirements at least as stringent as the requirements of sections 148.6401 to ~~148.6449~~ 148.645; or

~~(ii) the~~ (4) a person who meets the requirements for certification as an occupational therapist registered (OTR) or a certified occupational therapy assistant (COTA), established by the National Board for Certification in Occupational Therapy~~.~~; or

(5) an occupational therapy practitioner who possesses an active compact privilege under section 148.645.

Subd. 6. **Sanctions.** A person who practices occupational therapy or holds out as an occupational therapy practitioner by or through the use of any title described in subdivision 2 without prior licensure according to sections 148.6401 to ~~148.6449~~ 148.645 is subject to sanctions or action against continuing the activity according to section 148.6448, chapter 214, or other statutory authority.

Subd. 7. **Exemption.** Nothing in sections 148.6401 to ~~148.6449~~ 148.645 shall prohibit the practice of any profession or occupation licensed or registered by the state by any person duly licensed or registered to practice the profession or occupation or to perform any act that falls within the scope of practice of the profession or occupation.

Sec. 39. Minnesota Statutes 2024, section 148.6404, is amended to read:

148.6404 SCOPE OF PRACTICE.

(a) The practice of occupational therapy means the therapeutic use of everyday ~~activities~~ life occupations with individuals ~~or~~, groups, or populations for the purpose of enhancing or enabling participation in those occupations. ~~It is the promotion of~~ The practice of occupational therapy promotes health and well-being through the use of occupational therapy services that includes screening, evaluation, intervention, and consultation to develop, recover, and maintain a client's:

(1) sensory integrative, neuromuscular, motor, emotional, motivational, cognitive, or psychosocial components of performance;

(2) daily living skills;

(3) feeding and swallowing skills;

(4) play and leisure skills;

(5) educational participation skills;

(6) functional performance and work participation skills;

(7) community mobility; and

(8) health and wellness.

(b) Occupational therapy services include but are not limited to:

(1) designing, fabricating, or applying rehabilitative technology, such as selected orthotic and prosthetic devices, and providing training in the functional use of these devices;

(2) designing, fabricating, or adapting assistive technology and providing training in the functional use of assistive devices;

(3) adapting environments using assistive technology such as environmental controls, wheelchair modifications, and positioning; ~~and~~

(4) ~~employing~~ applying physical agent, manual, and mechanical modalities in preparation for or as an adjunct to purposeful activity to meet established functional occupational therapy goals; and

(5) educating and training individuals, including families, caregivers, groups, and populations.

(c) Occupational therapy services must be based on nationally established standards of practice.

Sec. 40. Minnesota Statutes 2024, section 148.6405, is amended to read:

148.6405 LICENSURE APPLICATION REQUIREMENTS: PROCEDURES AND QUALIFICATIONS.

(a) An applicant for licensure must comply with the application requirements in section 148.6420. To qualify for licensure, an applicant must satisfy one of the requirements in ~~paragraphs (b) to (f)~~ sections 148.6408 to 148.6415, or section 148.645 and not be subject to denial of licensure under section 148.6448.

~~(b) A person who applies for licensure as an occupational therapist and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6408.~~

~~(c) A person who applies for licensure as an occupational therapy assistant and who has not been credentialed by the National Board for Certification in Occupational Therapy or another jurisdiction must meet the requirements in section 148.6410.~~

~~(d) A person who is certified by the National Board for Certification in Occupational Therapy may apply for licensure by equivalency and must meet the requirements in section 148.6412.~~

~~(e) A person who is credentialed in another jurisdiction and who was previously certified by the National Board for Certification in Occupational Therapy may apply for licensure by reciprocity and must meet the requirements in section 148.6415.~~

~~(f)~~ (b) A person who applies for temporary licensure must meet the requirements in section 148.6418.

(c) A person who applies for licensure under section 148.6408 or 148.6410 more than two years after the person's initial NBCOT certification was issued and who has not practiced in any jurisdiction must submit:

(1) a completed and signed application for licensure on forms provided by the board that meet the requirements of section 148.6420, subdivision 1, paragraph (a), clauses (1) and (2); and

(2) proof of a minimum of 24 continuing education contact hours by an occupational therapist applicant, or a minimum of 18 hours by an occupational therapy assistant applicant, completed within the two years proceeding the application and meeting the requirements of section 148.6443.

~~(g)~~ (d) A person who applies for licensure under ~~paragraph (b), (c), or (f) more than two and less than four years after meeting the examination requirements in section 148.6408, subdivision 2, or 148.6410, subdivision 2,~~ section 148.6408 or 148.6410 after the person's initial NBCOT certification has expired must submit ~~the following~~:

(1) a completed and signed application for licensure on forms provided by the board that meet the requirements of section 148.6420, subdivision 1, paragraph (a), clauses (1) and (2); and

(2) ~~the license application fee required under section 148.6445;~~ evidence of:

(i) completion of an occupational therapy refresher program that contains both theoretical and clinical components completed within the last year; or

(ii) current NBCOT certification.

~~(3) if applying for occupational therapist licensure, proof of having met a minimum of 24 contact hours of continuing education in the two years preceding licensure application,~~

~~or if applying for occupational therapy assistant licensure, proof of having met a minimum of 18 contact hours of continuing education in the two years preceding licensure application;~~

~~(4) verified documentation of successful completion of 160 hours of supervised practice approved by the board under a limited license specified in section 148.6425, subdivision 3, paragraph (c); and~~

~~(5) additional information as requested by the board to clarify information in the application, including information to determine whether the individual has engaged in conduct warranting disciplinary action under section 148.6448. The information must be submitted within 30 calendar days from the date of the board's request.~~

~~(h) A person who applies for licensure under paragraph (b), (c), or (f) four years or more after meeting the examination requirements in section 148.6408, subdivision 2, or 148.6410, subdivision 2, must:~~

~~(1) meet all the requirements in paragraph (g) except clauses (3) and (4);~~

~~(2) submit documentation of having retaken and achieved a qualifying score on the credentialing examination for occupational therapists or occupational therapy assistants, or of having completed an occupational therapy refresher program that contains both a theoretical and clinical component approved by the board; and~~

~~(3) submit verified documentation of successful completion of 480 hours of supervised practice approved by the board under a limited license specified in section 148.6425, subdivision 3, paragraph (c). The 480 hours of supervised practice must be completed in six months and may be completed at the applicant's place of work. Only refresher courses completed within one year prior to the date of application qualify for approval.~~

Sec. 41. Minnesota Statutes 2024, section 148.6408, is amended by adding a subdivision to read:

Subd. 1a. **Qualifications.** To be licensed as an occupational therapist, an applicant must:

(1) satisfy the education and examination requirements of subdivisions 1b and 2; or

(2) satisfy the requirements for licensure by equivalency under section 148.6412 or licensure by reciprocity under section 148.6415 as applicable based on the current status of the applicant's NBCOT certification.

Sec. 42. Minnesota Statutes 2024, section 148.6408, subdivision 2, is amended to read:

Subd. 2. **Qualifying examination score required.** (a) An applicant must achieve a qualifying score on the ~~credentialing~~ certification examination for occupational therapist.

(b) The board shall determine the qualifying score for the ~~credentialing~~ certification examination for occupational therapist~~. In determining the qualifying score, the board shall consider the cut score~~ as recommended by the National Board for Certification in Occupational Therapy, or other national ~~credentialing~~ certification organization approved by the board~~, using the modified Angoff method for determining cut score or another method for determining cut score that is recognized as appropriate and acceptable by industry standards~~.

(c) ~~The applicant is responsible for~~ Applicants for licensure must:

(1) ~~making~~ make arrangements to take the ~~credentialing~~ certification examination for an occupational therapist;

(2) ~~bearing~~ bear all expenses associated with taking the examination; and

(3) ~~having the examination scores sent directly to the board from the testing service that administers the examination~~ submit an application and other materials as required by the board under section 148.6420.

Sec. 43. Minnesota Statutes 2024, section 148.6410, is amended by adding a subdivision to read:

Subd. 1a. **Qualifications.** To be licensed as an occupational therapist assistant, an applicant must:

(1) satisfy the education and examination requirements of subdivisions 1b and 2; or

(2) satisfy the requirements for licensure by equivalency under section 148.6412 or licensure by reciprocity under section 148.6415 as applicable based on the current status of the applicant's NBCOT certification.

Sec. 44. Minnesota Statutes 2024, section 148.6410, subdivision 2, is amended to read:

Subd. 2. **Qualifying examination score required.** (a) An applicant for licensure must achieve a qualifying score on the ~~credentialing~~ certification examination for occupational therapy assistants.

(b) The board shall determine the qualifying score for the ~~credentialing~~ certification examination for occupational therapy assistants~~. In determining the qualifying score, the~~

~~board shall consider the cut score~~ as recommended by the National Board for Certification in Occupational Therapy, or other national ~~credentialing~~ certification organization approved by the board~~, using the modified Angoff method for determining cut score or another method for determining cut score that is recognized as appropriate and acceptable by industry standards~~.

(c) ~~The applicant is responsible for~~ Applicants for licensure must:

(1) ~~making~~ make all arrangements to take the ~~credentialing~~ certification examination for occupational therapy assistants;

(2) ~~bearing~~ bear all expense associated with taking the examination; and

(3) ~~having the examination scores sent directly to the board from the testing service that administers the examination~~ submit an application and other materials as required by the board under section 148.6420.

Sec. 45. Minnesota Statutes 2024, section 148.6412, subdivision 2, is amended to read:

Subd. 2. **Persons currently certified by ~~National Board for Certification in Occupational Therapy~~ NBCOT.** The board may license any person ~~certified by the National Board for Certification in Occupational Therapy~~ who holds current NBCOT certification as an occupational ~~therapist if the board determines the requirements for certification are equivalent to or exceed the requirements for licensure as an occupational therapist under section 148.6408~~ therapy practitioner. ~~The board may license any person certified by the National Board for Certification in Occupational Therapy as an occupational therapy assistant if the board determines the requirements for certification are equivalent to or exceed the requirements for licensure as an occupational therapy assistant under section 148.6410.~~ Nothing in this section limits the board's authority to deny licensure based upon the grounds for discipline in sections 148.6401 to ~~148.6449~~ 148.645.

Sec. 46. Minnesota Statutes 2024, section 148.6412, subdivision 3, is amended to read:

Subd. 3. **Application procedures.** Applicants for licensure by equivalency must provide~~:~~

~~(1)~~ the application materials as required by section 148.6420, ~~subdivisions~~ subdivision 1~~, 3, and 4; and~~.

~~(2) the fees required by section 148.6445.~~

Sec. 47. Minnesota Statutes 2024, section 148.6415, is amended to read:

148.6415 LICENSURE BY RECIPROCITY.

~~A person who is not certified by the National Board for Certification in Occupational Therapy~~ The board may license any person who does not hold current NBCOT certification but who holds a compact privilege or a current credential as an occupational ~~therapist~~ therapy practitioner in the District of Columbia or a state or territory of the United States whose standards for credentialing are determined by the board to be equivalent to or exceed the requirements for licensure under section 148.6408 ~~may be eligible for licensure by reciprocity as an occupational therapist. A person who is not certified by the National Board for Certification in Occupational Therapy but who holds a current credential as an occupational therapy assistant in the District of Columbia or a state or territory of the United States whose standards for credentialing are determined by the board to be equivalent to or exceed the requirements for licensure under section 148.6410 may be eligible for licensure by reciprocity as an occupational therapy assistant.~~ or 148.6410 as an occupational therapy practitioner. Nothing in this section limits the board's authority to deny licensure based upon the grounds for discipline in sections 148.6401 to ~~148.6449~~ 148.645. An applicant must provide:

(1) the application materials as required by section 148.6420, ~~subdivisions~~ subdivision 1~~, 3, and 4~~; and

~~(2) the fees required by section 148.6445;~~

~~(3) a copy of a current and unrestricted credential for the practice of occupational therapy as either an occupational therapist or occupational therapy assistant;~~

~~(4) a letter from the jurisdiction that issued the credential describing the applicant's qualifications that entitled the applicant to receive the credential; and~~

~~(5)~~ (2) other information necessary to determine whether the credentialing standards of the jurisdiction that issued the credential are equivalent to or exceed the requirements for licensure under sections 148.6401 to ~~148.6449~~ 148.645.

Sec. 48. Minnesota Statutes 2024, section 148.6418, is amended to read:

148.6418 TEMPORARY LICENSURE.

Subdivision 1. **Application.** The board shall issue temporary licensure as an occupational ~~therapist or occupational~~ therapy ~~assistant~~ practitioner to applicants who are not the subject of a disciplinary action or past disciplinary action, nor disqualified on the basis of items listed in section 148.6448, subdivision 1.

Subd. 2. **Procedures.** To be eligible for temporary licensure, an applicant must submit a completed application for temporary licensure on forms provided by the board, the fees required by section 148.6445, and one of the following:

(1) evidence of successful completion of the requirements in section 148.6408, subdivision 1, or 148.6410, subdivision 1;

(2) a copy of a current and unrestricted credential for the practice of occupational therapy as ~~either~~ an occupational ~~therapist or occupational~~ therapy ~~assistant~~ practitioner in another jurisdiction; or

(3) a copy of a current and unrestricted ~~certificate~~ certification from the National Board for Certification in Occupational Therapy stating that the applicant is certified as an occupational ~~therapist or occupational~~ therapy ~~assistant~~ practitioner.

Subd. 3. **Additional documentation.** Persons who are ~~credentialed~~ certified by the National Board for Certification in Occupational Therapy or credentialed by another jurisdiction must provide ~~an affidavit~~ a statement with the application for temporary licensure stating that they are not the subject of a pending investigation or disciplinary action and have not been the subject of a disciplinary action in the past.

Subd. 4. **Supervision required.** An applicant who has graduated from an accredited occupational therapy program, as required by section 148.6408, subdivision 1, or 148.6410, subdivision 1, and who has not passed the examination required by section 148.6408, subdivision 2, or 148.6410, subdivision 2, must practice under the supervision of a licensed occupational therapist. The supervising therapist must, at a minimum, supervise the person working under temporary licensure in the performance of the initial evaluation, determination of the appropriate intervention plan, and periodic review and modification of the intervention plan. The supervising therapist must observe the person working under temporary licensure in order to ensure service competency in carrying out evaluation, intervention planning, and intervention implementation. The frequency of face-to-face collaboration between the person working under temporary licensure and the supervising therapist must be based on the condition of each patient or client, the complexity of intervention and evaluation procedures, and the proficiencies of the person practicing under temporary licensure. Following demonstrated service competency of the applicant, supervision must occur no less than every ten intervention days or every 30 calendar days, whichever occurs first. The occupational ~~therapist or occupational~~ therapy ~~assistant~~ practitioner working under temporary licensure must provide verification of supervision on the application form provided by the board. Supervising occupational therapists must have a minimum of six months of fully

licensed practice to supervise a temporary licensee. The occupational therapy practitioner working under temporary licensure must notify the board before changing supervision.

Subd. 5. **Qualifying examination requirement; expiration and renewability.** (a) A person issued a temporary license pursuant to subdivision 2, clause (1), must demonstrate to the board within the temporary licensure period successful completion of the qualifying examination requirement under section 148.6408, subdivision 2, or section 148.6410, subdivision 2. A temporary license holder who fails the qualifying examination for a second time shall have their temporary license revoked effective upon notification to the temporary license holder of the examination score. It is the temporary license holder's obligation to submit to the board their qualifying examination scores and to refrain from practice if their temporary license is revoked. Failure to do so subjects the temporary license holder to disciplinary action pursuant to section 148.6448, subdivision 1, clause ~~(5)~~ (6). The board must not issue a temporary license to a person with two or more certification examination failures.

(b) A temporary license expires six months from the date of issuance or on the date the board grants or denies licensure, whichever occurs first.

(c) A temporary license is not renewable.

Sec. 49. Minnesota Statutes 2024, section 148.6420, subdivision 1, is amended to read:

Subdivision 1. **Applications for initial licensure.** (a) An applicant for initial licensure must:

(1) submit a completed application for licensure on forms provided by the board and must supply ~~the~~ all information and documentation requested on the application, including:

(i) the applicant's name, business address and business telephone number, ~~business setting,~~ primary email address, and ~~daytime~~ home or mobile telephone number;

~~(ii) the name and location of the occupational therapy program the applicant completed;~~

~~(iii)~~ (ii) a description of the applicant's education and training, including the name and location of the occupational therapy program the applicant completed and a list of ~~degrees received from~~ all other educational institutions attended;

~~(iv)~~ (iii) the applicant's work history for the six years preceding the application;

~~(v)~~ (iv) a list of all credentials currently and previously held in Minnesota and other jurisdictions;

~~(vi)~~ (v) a description of any jurisdiction's refusal to credential the applicant;

~~(vii)~~ (vi) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction;

~~(viii)~~ (vii) information on any physical or mental condition or substance use disorder that impairs the person's ability to engage in the practice of occupational therapy with reasonable judgment or safety;

~~(ix)~~ (viii) a description of any misdemeanor or felony ~~conviction that relates to honesty or to the practice of occupational therapy~~ charges or convictions; ~~and~~

~~(x)~~ (ix) a description of any state or federal court order, including a conciliation court judgment or a disciplinary order, related to the individual's occupational therapy practice;

~~(2) submit with the application all fees required by section 148.6445;~~

~~(3) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;~~

~~(4) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant holds or previously held a credential for the practice of an occupation, has completed an accredited occupational therapy education program, or engaged in the practice of occupational therapy;~~

(x) any legal information required under chapter 214;

(xi) either documentation to demonstrate the completion of the required education and examination requirements under section 148.6408, subdivisions 1b and 2, or 148.6410, subdivisions 1b and 2; for applicants for licensure by equivalency under section 148.6412, documentation of current NBCOT certification; for applicants for licensure by reciprocity under section 148.6415, documentation submitted directly by the appropriate commission or government body verifying the license or credential; or verification from the Compact Commission of the applicant's practice status in Compact Commission states;

(xii) all application fees required by section 148.6445;

(xiii) evidence of completing a criminal background check according to section 214.075; and

(xiv) a signed statement affirming that the information in the application is true and correct to the best of the applicant's knowledge and belief;

~~(5)~~ (2) submit additional information as requested by the board; and

~~(6)~~ (3) submit ~~the~~ any additional information required for licensure by equivalency, licensure by reciprocity, licensure by compact privilege, and temporary licensure as specified

in sections 148.6408 to 148.6418. and 148.645. An applicant applying under section 148.6418 is exempt from providing documentation related to a criminal background check under clause (1), item (xiii). An applicant applying under section 148.6418, subdivision 4, is exempt from providing documentation related to previously held licenses or credentials under clause (1), item (iv).

(b) The board must not verify the status of an applicant under paragraph (a), clause (1), item (xi), by using another jurisdiction's publicly available website unless the other jurisdiction fails to provide the requested documentation after the applicant provides documentation of making the request.

Sec. 50. Minnesota Statutes 2024, section 148.6423, subdivision 1, is amended to read:

Subdivision 1. **Renewal requirements.** To be eligible for licensure renewal, a licensee must:

(1) submit a completed and signed application for licensure renewal, on forms provided by the board, including:

(i) updated personal information, including the renewal applicant's name, business address and business telephone number, primary email address, and home or mobile telephone number;

(ii) information regarding any change to the renewal applicant's responses to section 148.6420, subdivision 1, paragraph (a), clause (1), items (v) to (ix);

(iii) a signed statement affirming that the information in the renewal application is true and correct to the best of the applicant's knowledge and belief; and

(iv) any legal information required under chapter 214;

(2) submit the renewal fee required under section 148.6445;

(3) if audited, submit proof of having met the continuing education requirement of section 148.6443; and

(4) submit additional information as requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 calendar days of the board's request.

Sec. 51. Minnesota Statutes 2024, section 148.6423, is amended by adding a subdivision to read:

Subd. 1a. **License period.** Following the initial license period, a license period begins on the first day of the month after the licensee's birth month and must be renewed biennially.

Sec. 52. Minnesota Statutes 2024, section 148.6423, subdivision 2, is amended to read:

Subd. 2. **Renewal deadline.** (a) Except as provided in paragraph (c), licenses must be renewed every two years on or before the first day of the month after the licensee's birth month. Licensees must comply with the following procedures in paragraphs (b) to (e).

(b) Each license must state an expiration date. An application for licensure renewal must be received by the board ~~at least 30 calendar days~~ on or before the expiration date.

(c) If the board changes the renewal schedule and the expiration date is less than two years, the fee and the continuing education contact hours to be reported at the next renewal must be prorated.

(d) An application for licensure renewal not received within the time required under paragraph (b)~~, but received on or before the expiration date,~~ must be accompanied by a late fee in addition to the renewal fee specified by section 148.6445.

(e) Licensure renewals received after the expiration date must comply with the requirements of section 148.6425.

Sec. 53. Minnesota Statutes 2024, section 148.6425, subdivision 2, is amended to read:

Subd. 2. **Licensure renewal within one year after licensure expiration date.** A licensee whose application for licensure renewal is received after the licensure expiration date but within one year of the expiration date must submit the following:

(1) a completed and signed renewal application for licensure following lapse in licensed status~~;~~ on forms provided by the board, including:

(i) updated personal information, including the renewal applicant's name, business address and business telephone number, primary email address, and home or mobile telephone number;

(ii) information regarding any change to the renewal applicant's responses to section 148.6420, subdivision 1, paragraph (a), clause (1), items (v) to (ix);

(iii) a signed statement affirming that the information in the renewal application is true and correct to the best of the applicant's knowledge and belief;

(iv) information regarding any change to the renewal applicant's responses to section 148.6420, subdivision 1, paragraph (a), clause (1), item (xi);

(v) NBCOT verification of certification documentation; and

(vi) any legal information required under chapter 214;

(2) the renewal fee and the late fee required under section 148.6445;

(3) proof of having met the continuing education requirements in section 148.6443~~,~~ ~~subdivision 1~~; ~~and~~

(4) an employment verification form; and

~~(4)~~ (5) additional information as requested by the board to clarify information in the application, including information to determine whether the licensee has engaged in conduct warranting disciplinary action as set forth in section 148.6448. The information must be submitted within 30 calendar days from the date of the board's request.

Sec. 54. Minnesota Statutes 2024, section 148.6425, is amended by adding a subdivision to read:

Subd. 4. **Licensure renewal within two years after license expiration date.** A licensee whose application for license renewal is received more than one year but less than two years after the expiration date must submit the following:

(1) a completed and signed renewal application for licensure following lapse in licensed status on forms provided by the board, including all information listed in subdivision 2, clause (1);

(2) the renewal fee and the late fee required under section 148.6445;

(3) proof of having met the continuing education requirements in section 148.6443;

(4) an employment verification form;

(5) evidence of completion of a criminal background check as required under section 214.075 and the associated fee; and

(6) additional information as requested by the board to clarify information in the application, including information to determine whether the licensee has engaged in conduct warranting disciplinary action as set forth in section 148.6448. The information must be submitted within 30 calendar days from the date of the board's request.

Sec. 55. Minnesota Statutes 2024, section 148.6425, is amended by adding a subdivision to read:

Subd. 5. **Expiration due to nonrenewal after two years.** The board shall not renew, reissue, reinstate, or restore a license that is not subject to a pending review, investigation, or disciplinary action and has not been renewed within one biennial renewal cycle of the license expiration. An individual whose license has expired under this subdivision for nonrenewal must obtain a new license by applying for licensure and fulfilling all requirements then in existence for an initial license to practice occupational therapy in Minnesota.

Sec. 56. Minnesota Statutes 2024, section 148.6428, is amended to read:

148.6428 CHANGE OF CONTACT INFORMATION OR EMPLOYMENT.

A licensee who changes a name, primary email address, address, employment, business address, or business telephone number must inform the board of the change ~~of name, primary email address, address, employment, business address, or business telephone number~~ within 30 calendar days from the effective date of the change. A change in name must be accompanied by a copy of a marriage certificate, government-issued identification card, Social Security card, or court order. All notices or other correspondence served on a licensee by the board at the licensee's contact information on file with the board must be considered as having been received by the licensee.

Sec. 57. **[148.6431] JURISPRUDENCE EXAMINATION.**

The board may require occupational therapy practitioners to take an open-book jurisprudence examination on state laws and rules regarding the practice of occupational therapy and occupational therapy assisting.

Sec. 58. Minnesota Statutes 2024, section 148.6432, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** If the professional standards identified in ~~section 148.6430~~ subdivision 1a permit an occupational therapist to delegate an evaluation, reevaluation, or treatment procedure, the occupational therapist must provide supervision consistent with this section.

Sec. 59. Minnesota Statutes 2024, section 148.6432, is amended by adding a subdivision to read:

Subd. 1a. **Delegation of duties.** (a) The occupational therapist may delegate to an occupational therapy assistant those portions of the client's evaluation, reevaluation, and

intervention that, according to prevailing national practice standards, can be performed by an occupational therapy assistant.

(b) The occupational therapist is responsible for all duties delegated to the occupational therapy assistant.

(c) The occupational therapist may not delegate portions of an evaluation or reevaluation of a person whose condition is changing rapidly.

Sec. 60. Minnesota Statutes 2024, section 148.6432, subdivision 2, is amended to read:

Subd. 2. **Evaluations.** The occupational therapist shall determine the frequency of evaluations and reevaluations for each client. The occupational therapy assistant shall inform the occupational therapist of the need for more frequent reevaluation if indicated by the client's condition or response to treatment. Before delegating a portion of a client's evaluation pursuant to ~~section 148.6430~~ subdivision 1a, the occupational therapist shall ensure the service competency of the occupational therapy assistant in performing the evaluation procedure and shall provide supervision consistent with the condition of the patient or client and the complexity of the evaluation procedure.

Sec. 61. Minnesota Statutes 2024, section 148.6432, subdivision 3, is amended to read:

Subd. 3. **Intervention.** (a) The occupational therapist must determine the frequency and manner of supervision of an occupational therapy assistant performing intervention procedures delegated pursuant to ~~section 148.6430~~ subdivision 1a based on the condition of the patient or client, the complexity of the intervention procedure, and the service competency of the occupational therapy assistant.

(b) Face-to-face collaboration between the occupational therapist and the occupational therapy assistant must occur for all clients every ten intervention days or every 30 days, whichever comes first, during which time the occupational therapist is responsible for:

(1) planning and documenting an initial intervention plan and discharge from interventions;

(2) reviewing intervention goals, therapy programs, and client progress;

(3) supervising changes in the intervention plan;

(4) conducting or observing intervention procedures for selected clients and documenting appropriateness of intervention procedures. Clients must be selected based on the

occupational therapy services provided to the client and the role of the occupational therapist and the occupational therapy assistant in those services; and

(5) ensuring the service competency of the occupational therapy assistant in performing delegated intervention procedures.

(c) Face-to-face collaboration must occur more frequently if necessary to meet the requirements of paragraph (a) or (b).

(d) The occupational therapist must document compliance with this subdivision in the client's file or chart.

Sec. 62. Minnesota Statutes 2024, section 148.6432, subdivision 4, is amended to read:

Subd. 4. **Exception.** (a) The supervision requirements of this section do not apply to an occupational therapy assistant who:

(1) works in an activities program; and

(2) does not perform occupational therapy services.

(b) The occupational therapy assistant must meet all other applicable requirements of sections 148.6401 to ~~148.6449~~ 148.645.

Sec. 63. Minnesota Statutes 2024, section 148.6435, is amended to read:

148.6435 COORDINATION OF SERVICES.

An occupational therapist must:

(1) collect information necessary to ensure that the provision of occupational therapy services are consistent with the client's physical and mental health status. The information required to make this determination may include, but is not limited to, contacting the client's licensed health care professional for health history, current health status, current medications, and precautions;

~~(2) modify or terminate occupational therapy intervention of a client that is not beneficial to the client, not tolerated by the client, or refused by the client, and if intervention was terminated for a medical reason, notify the client's licensed health care professional by correspondence postmarked or delivered to the licensed health care professional within one week of the termination of intervention;~~

~~(3)~~ (2) refer a client to an appropriate health care, social service, or education practitioner if the client's condition requires services not within the occupational therapist's service

competency or not within the practice of occupational therapy generally, or if the client's acuity warrants alternative care; and

~~(4)~~ (3) participate and cooperate in the coordination of occupational therapy services with other related services, as a member of the professional community serving the client.

Sec. 64. Minnesota Statutes 2024, section 148.6438, is amended to read:

148.6438 RECIPIENT NOTIFICATION.

Subdivision 1. **Required notification.** (a) In the absence of a ~~physician, advanced practice registered nurse, or physician assistant~~ licensed health care provider referral or prior authorization, and before providing occupational therapy services for remuneration or expectation of payment from the client, an occupational therapist must provide the following ~~written~~ notification ~~in all capital letters of 12-point or larger boldface type,~~ to the client, parent, or guardian in a format meeting national accessibility standards and the needs of the client, parent, or guardian:

"Your health care provider, insurer, or plan may require a ~~physician, advanced practice registered nurse, or physician assistant~~ licensed health care provider referral or prior authorization and you may be obligated for partial or full payment for occupational therapy services rendered."

(b) Information other than this notification may be included as long as the notification remains conspicuous on the face of the document. ~~A nonwritten disclosure format may be used to satisfy the recipient notification requirement when necessary to accommodate the physical condition of a client or client's guardian.~~

Subd. 2. **Evidence of recipient notification.** The occupational therapist is responsible for providing evidence of compliance with the recipient notification requirement of this section with documentation of the client, parent, or guardian agreement.

Sec. 65. Minnesota Statutes 2024, section 148.6443, subdivision 3, is amended to read:

Subd. 3. **Activities qualifying for continuing education contact hours.** (a) The activities in this subdivision qualify for continuing education contact hours if they meet all other requirements of this section.

(b) A minimum of one-half of the required contact hours must be directly related to occupational therapy practice. The remaining contact hours may be related to occupational therapy practice, the delivery of occupational therapy services, or to the practitioner's current professional role.

(c) A licensee may obtain an unlimited number of contact hours in any two-year continuing education period through participation in the following:

(1) attendance at educational programs of annual conferences, lectures, panel discussions, workshops, in-service training, seminars, and symposiums;

(2) successful completion of college or university courses. The licensee must obtain a grade of at least a "C" or a pass in a pass/fail course in order to receive credit. One college credit equals six continuing education contact hours; or

(3) successful completion of ~~home study~~ courses that ~~require the participant to demonstrate the participant's knowledge following completion of the course~~ provide documentation that the course was completed and that meet the requirements in subdivision 2.

(d) A licensee may obtain a maximum of one-half of the required contact hours in any two-year continuing education period for:

(1) teaching continuing education or occupational therapy related courses that meet the requirements of this section. A licensee is entitled to earn a maximum of two contact hours as preparation time for each contact hour of presentation time. Contact hours may be claimed only once for teaching the same course in any two-year continuing education period. A course schedule or brochure must be maintained for audit;

(2) supervising occupational therapist or occupational therapy assistant students. A licensee may earn one contact hour for every eight hours of student supervision. Licensees must ensure they receive documentation regarding each student supervised and the dates and hours each student was supervised. Contact hours obtained by student supervision must be obtained by supervising students from an occupational therapy education program accredited by the Accreditation Council for Occupational Therapy Education; and

~~(3) teaching or participating in courses related to leisure activities, recreational activities, or hobbies if the practitioner uses these interventions within the practitioner's current practice or employment; and~~

~~(4)~~ (3) engaging in research activities or outcome studies that are related to the practice of occupational therapy and associated with grants, postgraduate studies, or publications in professional journals or books.

(e) A licensee may obtain a maximum of two contact hours in any two-year continuing education period for continuing education activities in the following areas:

(1) personal skill topics: career burnout, communication skills, human relations, and similar topics;

(2) ~~training that is obtained in conjunction with a licensee's employment, occurs during a licensee's normal workday, and does not include subject matter specific to the fundamentals of occupational therapy~~ basic life support and CPR training; and

(3) participation for a minimum of one year on a professional committee or board.

Sec. 66. Minnesota Statutes 2024, section 148.6443, subdivision 4, is amended to read:

Subd. 4. **Activities not qualifying for continuing education contact hours.** Credit must not be granted for the following activities: hospital patient rounds~~,~~; entertainment or recreational activities~~,~~; volunteering; noneducational association meetings~~,~~; and employment orientation sessions and meetings, including but not limited to training required at the beginning of employment, annually, or routinely that is related to the employer's organization requirements.

Sec. 67. Minnesota Statutes 2024, section 148.6443, subdivision 5, is amended to read:

Subd. 5. **Reporting continuing education contact hours.** Each licensee must use the continuing education reporting form to verify meeting the continuing education requirements of this section. The licensee must maintain documentation, including but not limited to a signed certificate, transcript, or similar evidence of participation in an activity. The documentation must include ~~a~~:

(1) the title of the continuing education activity;

(2) a brief description of the continuing education activity prepared by the presenter or sponsor;

(3) the name of the sponsor, presenter, or author;

(4) the location and attendance dates;

(5) the number of contact hours; and

(6) the licensee's name.

Sec. 68. Minnesota Statutes 2024, section 148.6443, subdivision 6, is amended to read:

Subd. 6. **Auditing continuing education reports.** (a) The board may audit a percentage of the continuing education reports based on random selection. A licensee shall maintain

all documentation required by this section for two years after the last day of the biennial licensure period in which the contact hours were earned.

(b) All renewal applications that are received after the expiration date may be subject to a continuing education report audit.

(c) Any licensee against whom a complaint is filed may be subject to a continuing education report audit.

(d) The licensee shall make the following information available to the board for auditing purposes:

(1) a copy of the completed continuing education reporting form for the continuing education reporting period that is the subject of the audit including all supporting documentation required by subdivision 5;

(2) documentation of university, college, or vocational school courses by a transcript and a course syllabus, listing in a course bulletin, or equivalent documentation that includes the course title, instructor's name, course dates, number of contact hours, and course content, objectives, or goals; and

(3) verification of attendance ~~by~~ that meets the requirements of subdivision 5 by submitting:

(i) a ~~signature of~~ certificate of attendance, or if a certificate is not available, other documentation from the presenter or a designee ~~at the continuing education activity on the continuing education report form or a certificate of attendance with the course name, course date, and licensee's name~~ submitted directly to the board confirming the requirements; or

~~(ii) a summary or outline of the educational content of an audio or video educational activity to verify the licensee's participation in the activity if a designee is not available to sign the continuing education report form; or~~

~~(iii)~~ (ii) verification of self-study programs by a certificate of completion ~~or other documentation indicating that the individual has demonstrated knowledge and has successfully completed the program~~.

Sec. 69. Minnesota Statutes 2024, section 148.6443, subdivision 7, is amended to read:

Subd. 7. **~~Waiver~~ Deferral of continuing education requirements.** The board may ~~waive or~~ defer all or part of the continuing education requirements of this section if the licensee submits a written request and provides satisfactory evidence to the board of illness, injury, financial hardship, family hardship, or other similar extenuating circumstances that

preclude completion of the requirements during the licensure period. The request for a ~~waiver~~ deferral must be in writing, state the circumstances that constitute hardship, state the period of time the licensee wishes to have the continuing education requirement ~~waived~~ deferred, and state the alternative measures that will be taken if a ~~waiver~~ deferral is granted. The board must set forth, in writing, the reasons for granting or denying the ~~waiver~~ deferral. ~~Waivers~~ Deferrals granted by the board must specify, in writing, the time limitation and required alternative measures to be taken by the licensee. A request for ~~waiver~~ deferral must be denied if the board finds that the circumstances stated by the licensee do not support a claim of hardship, the requested time period for ~~waiver~~ deferral is unreasonable, the alternative measures proposed by the licensee are not equivalent to the continuing education activity being ~~waived~~ deferred, or the request for ~~waiver~~ deferral is not submitted to the board within 60 calendar days of the expiration date.

Sec. 70. Minnesota Statutes 2024, section 148.6443, subdivision 8, is amended to read:

Subd. 8. **Penalties for noncompliance.** The board shall refuse to renew or grant, or shall suspend, condition, limit, or otherwise qualify the license of any person who the board determines has failed to comply with the continuing education requirements of this section. A licensee may request reconsideration of the board's determination of noncompliance or the penalty imposed under this section by making a written request to the board within 30 calendar days of the date of notification to the applicant. Individuals requesting reconsideration may submit information that the licensee wants considered in the reconsideration.

Sec. 71. Minnesota Statutes 2024, section 148.6445, is amended by adding a subdivision to read:

Subd. 5a. **Compact privilege fee.** The fee for interstate licensure compact privilege to practice is $150.

Sec. 72. Minnesota Statutes 2024, section 148.6445, is amended by adding a subdivision to read:

Subd. 7a. **Active mailing list.** The fee for the standard active licensee mailing list delivered electronically is $500.

Sec. 73. Minnesota Statutes 2024, section 148.6448, subdivision 1, is amended to read:

Subdivision 1. **Grounds for denial of licensure or discipline.** The board may deny an application for licensure, may approve licensure with conditions, or may discipline a licensee using any disciplinary actions listed in subdivision 3 on proof that the individual has:

(1) intentionally submitted false or misleading information to the board;

(2) obtained a license by means of fraud, misrepresentation, or concealment of material facts;

(3) failed, within 30 days, to provide information in response to a written request by the board;

~~(3)~~ (4) performed services of an occupational ~~therapist or occupational~~ therapy ~~assistant~~ practitioner in an incompetent manner or in a manner that falls below the community standard of care or national practice standards of care;

~~(4)~~ (5) failed to satisfactorily perform occupational therapy services during a period of temporary licensure;

~~(5)~~ (6) violated sections 148.6401 to ~~148.6449~~ 148.645;

~~(6)~~ (7) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

~~(7)~~ (8) been convicted of violating any state or federal law, rule, or regulation ~~which directly~~ that reasonably relates to the practice of occupational therapy;

(9) failed to report other licensees that have violated sections 148.6401 to 148.645;

~~(8)~~ (10) aided or abetted another person in violating any provision of sections 148.6401 to ~~148.6449~~ 148.645;

~~(9)~~ (11) been disciplined for conduct in the practice of an occupation by the state of Minnesota, another jurisdiction, or a national professional association, if any of the grounds for discipline are the same or substantially equivalent to those in sections 148.6401 to ~~148.6449~~ 148.645;

~~(10)~~ (12) not cooperated with the board in an investigation conducted according to subdivision 2;

~~(11)~~ (13) advertised in a manner that is false or misleading;

~~(12)~~ (14) engaged in dishonest, unethical, or unprofessional conduct in connection with the practice of occupational therapy that is likely to deceive, defraud, or harm the public;

(15) improperly managed client records, including but not limited to failure to maintain client records in a manner that meets community standards of care or nationally accepted practice standards;

~~(13)~~ (16) demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(17) inappropriately supervised or delegated or assigned tasks to an occupational therapy assistant, occupational therapy student, rehabilitation aide, or other licensed professional;

~~(14)~~ (18) performed medical diagnosis or provided intervention, other than occupational therapy, without being licensed to do so under the laws of this state;

~~(15)~~ (19) paid or promised to pay a commission or part of a fee to any person who contacts the occupational ~~therapist~~ therapy practitioner for consultation or sends patients to the occupational ~~therapist~~ therapy practitioner for intervention;

~~(16)~~ (20) engaged in an incentive payment arrangement, other than that prohibited by clause ~~(15)~~ (19), that promotes occupational therapy overutilization, whereby the referring person or person who controls the availability of occupational therapy services to a client profits unreasonably as a result of client intervention;

~~(17)~~ (21) engaged in abusive or fraudulent billing practices~~, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws~~;

~~(18)~~ (22) obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

~~(19)~~ (23) performed services for a client who had no possibility of benefiting from the services;

~~(20)~~ (24) failed to refer a client for medical evaluation when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

~~(21)~~ (25) engaged in conduct with a client that is sexual or may reasonably be interpreted by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

~~(22)~~ (26) violated a federal or state court order, including a conciliation court judgment, or a disciplinary order issued by the board, related to the person's occupational therapy practice; or

~~(23)~~ (27) any other just cause related to the practice of occupational therapy.

Sec. 74. Minnesota Statutes 2024, section 148.6448, subdivision 2, is amended to read:

Subd. 2. **Investigation of complaints.** The board may initiate an investigation upon receiving a complaint or other oral or written communication that alleges or implies that a person has violated sections 148.6401 to ~~148.6449~~ 148.645. In the receipt, investigation, and hearing of a complaint that alleges or implies a person has violated sections 148.6401 to ~~148.6449~~ 148.645, the board must follow the procedures in sections 214.10 and 214.103.

Sec. 75. Minnesota Statutes 2024, section 148.6448, subdivision 4, is amended to read:

Subd. 4. **Effect of specific disciplinary action on use of title.** Upon notice from the board denying licensure renewal or upon notice that disciplinary actions have been imposed and the person is no longer entitled to practice occupational therapy and use the occupational therapy and licensed titles, the person shall cease to practice occupational therapy, to use titles protected by sections 148.6401 to ~~148.6449~~ 148.645, and to represent to the public that the person is licensed by the board.

Sec. 76. Minnesota Statutes 2024, section 148.6448, subdivision 6, is amended to read:

Subd. 6. **Authority to contract.** The board shall contract with the health professionals services program as authorized by sections 214.31 to 214.37 to provide these services to practitioners under this chapter. The health professionals services program does not affect the board's authority to discipline violations of sections 148.6401 to ~~148.6449~~ 148.645.

Sec. 77. Minnesota Statutes 2024, section 148.6449, subdivision 1, is amended to read:

Subdivision 1. **Creation.** The Board of Occupational Therapy Practice consists of 11 members appointed by the governor. The members are:

(1) five occupational therapists licensed under sections 148.6401 to ~~148.6449~~ 148.645;

(2) three occupational therapy assistants licensed under sections 148.6401 to ~~148.6449~~ 148.645; and

(3) three public members, including two members who have received occupational therapy services or have a family member who has received occupational therapy services, and one member who is a health care professional or health care provider licensed in Minnesota.

Sec. 78. Minnesota Statutes 2024, section 148.6449, subdivision 2, is amended to read:

Subd. 2. **Qualifications of board members.** (a) The occupational therapy practitioners appointed to the board must represent a variety of practice areas and settings.

(b) At least ~~two occupational therapy practitioners~~ three members of the board must be employed or reside outside the seven-county metropolitan area.

(c) Board members must not serve for more than two full consecutive terms.

(d) Interstate licensure compact privilege holders are not eligible to serve on the board.

Sec. 79. Minnesota Statutes 2024, section 148.6449, subdivision 7, is amended to read:

Subd. 7. **Duties of the Board of Occupational Therapy Practice.** (a) The board shall:

(1) adopt and enforce rules and laws necessary for licensing occupational therapy practitioners;

(2) adopt and enforce rules for regulating the professional conduct of the practice of occupational therapy;

(3) issue licenses to qualified individuals in accordance with sections 148.6401 to ~~148.6449~~ 148.645;

(4) assess and collect fees for the issuance and renewal of licenses;

(5) educate the public about the requirements for licensing occupational therapy practitioners, educate occupational therapy practitioners about the rules of conduct, and enable the public to file complaints against applicants and licensees who may have violated sections 148.6401 to ~~148.6449~~ 148.645; and

(6) investigate individuals engaging in practices that violate sections 148.6401 to ~~148.6449~~ 148.645 and take necessary disciplinary, corrective, or other action according to section 148.6448.

(b) The board may adopt rules necessary to define standards or carry out the provisions of sections 148.6401 to ~~148.6449~~ 148.645. Rules shall be adopted according to chapter 14.

Sec. 80. Minnesota Statutes 2024, section 148B.53, subdivision 3, is amended to read:

Subd. 3. **~~Fee~~ Fees.** Nonrefundable fees are as follows:

(1) initial license application fee for licensed professional counseling (LPC) - $150;

(2) initial license fee for LPC - $250;

(3) annual active license renewal fee for LPC - $250 or equivalent;

(4) annual inactive license renewal fee for LPC - $125;

(5) initial license application fee for licensed professional clinical counseling (LPCC) - $150;

(6) initial license fee for LPCC - $250;

(7) annual active license renewal fee for LPCC - $250 or equivalent;

(8) annual inactive license renewal fee for LPCC - $125;

(9) license renewal late fee - $100 per month or portion thereof;

(10) copy of board order or stipulation - $10;

(11) certificate of good standing or license verification - $25;

(12) duplicate certificate fee - $25;

(13) professional firm renewal fee - $25;

(14) sponsor application for approval of a continuing education course - $60;

(15) initial registration fee - $50;

(16) annual registration renewal fee - $25;

(17) approved supervisor application processing fee - $30; ~~and~~

(18) temporary license for members of the military - $250; and

(19) interstate compact privilege to practice fee - not to exceed $100.

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

Sec. 81. Minnesota Statutes 2024, section 148E.180, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** (a) Nonrefundable application fees for licensure may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, $75;

(2) for a licensed graduate social worker, $75;

(3) for a licensed independent social worker, $75;

(4) for a licensed independent clinical social worker, $75;

(5) for a temporary license, $50; ~~and~~

(6) for a license by endorsement, $115; and

(7) for a compact multistate license, $75.

(b) The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

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

Sec. 82. Minnesota Statutes 2024, section 148E.180, is amended by adding a subdivision to read:

Subd. 2a. **Compact multistate license fees.** Nonrefundable compact multistate license fees must not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, $115;

(2) for a licensed graduate social worker, $210;

(3) for a licensed independent social worker, $305; and

(4) for a licensed independent clinical social worker, $335.

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

Sec. 83. Minnesota Statutes 2024, section 148E.180, is amended by adding a subdivision to read:

Subd. 3a. **Compact multistate renewal fees.** Nonrefundable renewal fees for compact multistate licensure must not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, $115;

(2) for a licensed graduate social worker, $210;

(3) for a licensed independent social worker, $305; and

(4) for a licensed independent clinical social worker, $335.

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

Sec. 84. Minnesota Statutes 2024, section 148E.180, subdivision 5, is amended to read:

Subd. 5. **Late fees.** Late fees are the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the applicable renewal fee specified in ~~subdivision~~ subdivisions 3 and 3a;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the applicable license ~~fee~~ fees specified in ~~subdivision~~ subdivisions 2 and 2a for the number of months during which the individual practiced social work without a license.

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

Sec. 85. Minnesota Statutes 2024, section 148E.180, subdivision 7, is amended to read:

Subd. 7. **Reactivation fees.** Reactivation fees are the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the applicable renewal fees specified in ~~subdivision~~ subdivisions 3 and 3a.

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

Sec. 86. **[148G.01] TITLE.**

This chapter shall be referred to as the Minnesota Certified Midwife Practice Act.

Sec. 87. **[148G.02] SCOPE.**

This chapter applies to all applicants and licensees, all persons who use the title certified midwife, and all persons in or out of this state who provide certified midwifery services to patients who reside in this state, unless there are specific applicable exemptions provided by law.

Sec. 88. **[148G.03] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter, the definitions in this section have the meanings given.

Subd. 2. **Board.** "Board" means the Minnesota Board of Nursing.

Subd. 3. **Certification.** "Certification" means the formal recognition by the American Midwifery Certification Board of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the American College of Nurse Midwives or any successor organization.

Subd. 4. **Certified midwife.** "Certified midwife" means an individual who holds a current and valid national certification as a certified midwife from the American Midwifery Certification Board or any successor organization and who is licensed by the board under this chapter.

Subd. 5. **Certified midwifery practice.** "Certified midwifery practice" means:

(1) managing, diagnosing, and treating women's primary health care beginning in adolescence, including pregnancy, childbirth, the postpartum period, care of the newborn, family planning, partner care management relating to sexual health, and gynecological care of women;

(2) ordering, performing, supervising, and interpreting diagnostic studies within the scope of certified midwifery practice, excluding:

(i) interpreting and performing specialized ultrasound examinations; and

(ii) interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;

(3) prescribing pharmacologic and nonpharmacologic therapies appropriate to midwifery practice;

(4) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient; and

(5) performing the role of educator in the theory and practice of midwifery.

Subd. 6. **Collaborating.** "Collaborating" means the process in which two or more health care professionals work together to meet the health care needs of a patient, as warranted by the needs of the patient.

Subd. 7. **Consulting.** "Consulting" means the process in which a certified midwife who maintains primary management responsibility for a patient's care seeks advice or opinion of a physician, an advanced practice registered nurse, or another member of the health care team.

Subd. 8. **Encumbered.** "Encumbered" means:

(1) a license or other credential that is revoked, is suspended, or contains limitations on the full and unrestricted practice of certified midwifery when the revocation, suspension, or limitation is imposed by a state licensing board or other state regulatory entity; or

(2) a license or other credential that is voluntarily surrendered.

Subd. 9. **Licensure period.** "Licensure period" means the interval of time during which the certified midwife is authorized to engage in certified midwifery. The initial licensure period is from six to 29 full calendar months starting on the day of licensure and ending on the last day of the certified midwife's month of birth in an even-numbered year if the year of birth is an even-numbered year, or in an odd-numbered year if the year of birth is an odd-numbered year. Subsequent licensure renewal periods are 24 months. For licensure renewal, the period starts on the first day of the month following expiration of the previous licensure period. The period ends the last day of the certified midwife's month of birth in an even- or odd-numbered year according to the certified midwife's year of birth.

Subd. 10. **Licensed practitioner.** "Licensed practitioner" means a physician licensed under chapter 147, an advanced practice registered nurse licensed under sections 148.171 to 148.235, or a certified midwife licensed under this chapter.

Subd. 11. **Midwifery education program.** "Midwifery education program" means a program of theory and practice offered by a university or college that leads to the preparation and eligibility for certification in midwifery and is accredited by the Accreditation Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation.

Subd. 12. **Patient.** "Patient" means a recipient of care provided by a certified midwife within the scope of certified midwifery practice, including an individual, family, group, or community.

Subd. 13. **Prescribing.** "Prescribing" means the act of generating a prescription for the preparation of, use of, or manner of using a drug or therapeutic device under section 148G.09. Prescribing does not include recommending the use of a drug or therapeutic device that is not required by the federal Food and Drug Administration to meet the labeling requirements for prescription drugs and devices.

Subd. 14. **Prescription.** "Prescription" means a written direction or an oral direction reduced to writing provided to or for a patient for the preparation or use of a drug or therapeutic device. The requirements of section 151.01, subdivisions 16, 16a, and 16b, apply to prescriptions for drugs.

Subd. 15. **Referral.** "Referral" means the process in which a certified midwife directs a patient to a physician or another health care professional for management of a particular problem or aspect of the patient's care.

Subd. 16. **Supervision.** "Supervision" means monitoring and establishing the initial direction of, setting expectations for, directing activities in, evaluating, and changing a course of action in certified midwifery care.

Sec. 89. **[148G.04] CERTIFIED MIDWIFE LICENSING.**

Subdivision 1. **Licensure.** (a) No person shall practice as a certified midwife or serve as the faculty of record for clinical instruction in a midwifery distance learning program unless the person is licensed by the board under this chapter.

(b) An applicant for a license to practice as a certified midwife must apply to the board in a format prescribed by the board and pay a fee in an amount determined under section 148G.11.

(c) To be eligible for licensure, an applicant must:

(1) not hold an encumbered license or other credential as a certified midwife or equivalent professional designation in any state or territory;

(2) hold a current and valid certification as a certified midwife from the American Midwifery Certification Board or any successor organization acceptable to the board and provide primary source verification of certification to the board in a format prescribed by the board;

(3) have completed a graduate level midwifery education program that includes clinical experience, is accredited by the Accreditation Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation, and leads to a graduate degree. The applicant must submit primary source verification of program completion to the board in a format prescribed by the board. The primary source verification must verify the applicant completed three separate graduate-level courses in physiology and pathophysiology; advanced health assessment; and advanced pharmacology, including pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents;

(4) report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction; and

(5) not have committed any acts or omissions that are grounds for disciplinary action in another jurisdiction or, if these acts were committed and would be grounds for disciplinary action as set forth in section 148G.13, the board has found after an investigation that sufficient remediation was made.

Subd. 2. **Clinical practice component.** If more than five years have elapsed since the applicant has practiced in the certified midwife role, the applicant must complete a reorientation plan as a certified midwife. The plan must include supervision during the clinical component by a licensed practitioner with experience in providing care to patients with the same or similar health care needs. The applicant must submit the plan and the name of the practitioner to the board. The plan must include a minimum of 500 hours of supervised certified midwifery practice. The certified midwife must submit verification of completion of the clinical reorientation to the board when the reorientation is complete.

Sec. 90. **[148G.05] LICENSURE RENEWAL; RELICENSURE.**

Subdivision 1. **Renewal; current applicants.** (a) A certified midwife must apply for renewal of the certified midwife's license before the certified midwife's licensure period ends. To be considered timely, the board must receive the certified midwife's application on or before the last day of the certified midwife's licensure period. A certified midwife's license lapses if the certified midwife's application is untimely.

(b) An applicant for license renewal must provide the board evidence of current certification or recertification as a certified midwife by the American Midwifery Certification Board or any successor organization.

(c) An applicant for license renewal must submit to the board the fee under section 148G.11, subdivision 2.

Subd. 2. **Clinical practice component.** If more than five years have elapsed since the applicant has practiced as a certified midwife, the applicant must complete a reorientation plan as a certified midwife. The plan must include supervision during the clinical component by a licensed practitioner with experience in providing care to patients with the same or similar health care needs. The licensee must submit the plan and the name of the practitioner to the board. The plan must include a minimum of 500 hours of supervised certified midwifery practice. The certified midwife must submit verification of completion of the clinical reorientation to the board when the reorientation is complete.

Subd. 3. **Relicensure; lapsed applicants.** A person whose license has lapsed who desires to resume practice as a certified midwife must apply for relicensure, submit to the board satisfactory evidence of compliance with the procedures and requirements established by the board, and pay the board the relicensure fee under section 148G.11, subdivision 4, for the current licensure period. A penalty fee under section 148G.11, subdivision 4, is required from a person who practiced certified midwifery without current licensure. The board must relicense a person who meets the requirements of this subdivision.

Sec. 91. **[148G.06] FAILURE OR REFUSAL TO PROVIDE INFORMATION.**

Subdivision 1. **Notification requirement.** An individual licensed as a certified midwife must notify the board when the individual renews their certification. If a licensee fails to provide notification, the licensee is prohibited from practicing as a certified midwife.

Subd. 2. **Denial of license.** Refusal of an applicant to supply information necessary to determine the applicant's qualifications, failure to demonstrate qualifications, or failure to satisfy the requirements for a license contained in this chapter or rules of the board may result in denial of a license. The burden of proof is upon the applicant to demonstrate the qualifications and satisfaction of the requirements.

Sec. 92. **[148G.07] NAME CHANGE AND CHANGE OF ADDRESS.**

A certified midwife must maintain a current name and address with the board and must notify the board in writing within 30 days of any change in name or address. All notices or other correspondence mailed to or served upon a certified midwife by the board at the licensee's address on file with the board are considered received by the licensee.

Sec. 93. **[148G.08] IDENTIFICATION OF CERTIFIED MIDWIVES.**

Only those persons who hold a current license to practice certified midwifery in Minnesota may use the title of certified midwife. A certified midwife licensed by the board must use the designation of "CM" for professional identification and in documentation of services provided.

Sec. 94. **[148G.09] PRESCRIBING DRUGS AND THERAPEUTIC DEVICES.**

Subdivision 1. **Diagnosing, prescribing, and ordering.** Certified midwives, within the scope of certified midwifery practice, are authorized to:

(1) diagnose, prescribe, and institute therapy or referrals of patients to health care agencies and providers;

(2) prescribe, procure, sign for, record, administer, and dispense over-the-counter, legend, and controlled substances, including sample drugs; and

(3) plan and initiate a therapeutic regimen that includes ordering and prescribing durable medical devices and equipment, nutrition, diagnostic services, and supportive services, including but not limited to home health care, physical therapy, and occupational therapy.

Subd. 2. **Drug Enforcement Administration requirements.** (a) Certified midwives must:

(1) comply with federal Drug Enforcement Administration (DEA) requirements related to controlled substances; and

(2) file the certified midwife's DEA registrations and numbers, if any, with the board.

(b) The board must maintain current records of all certified midwives with a DEA registration and number.

Sec. 95. **[148G.10] FEES.**

The fees specified in section 148G.11 are nonrefundable and must be deposited in the state government special revenue fund.

Sec. 96. **[148G.11] FEE AMOUNTS.**

Subdivision 1. **Licensure.** The fee for licensure is $105.

Subd. 2. **Renewal.** The fee for licensure renewal is $85.

Subd. 3. **Practicing without current certification.** The penalty fee for a person who practices certified midwifery without a current certification or recertification, or who practices certified midwifery without current certification or recertification on file with the board, is $200 for the first month or part of a month and an additional $100 for each subsequent month or parts of months of practice. The penalty fee must be calculated from the first day the certified midwife practiced without a current certification to the last day of practice without a current certification, or from the first day the certified midwife practiced without a current certification or recertification on file with the board until the day the current certification or recertification is filed with the board.

Subd. 4. **Relicensure.** The fee for relicensure is $105. The fee for practicing without current licensure is two times the amount of the current renewal fee for any part of the first calendar month, plus the current renewal fee for any part of each subsequent month up to 24 months.

Subd. 5. **Dishonored check fee.** The service fee for a dishonored check is as provided in section 604.113.

Sec. 97. **[148G.12] APPROVED MIDWIFERY EDUCATION PROGRAM.**

Subdivision 1. **Initial approval.** A university or college desiring to conduct a certified midwifery education program must submit evidence to the board that the university or college is prepared to:

(1) provide a program of theory and practice in certified midwifery leading to eligibility for certification in midwifery;

(2) achieve preaccreditation and eventual full accreditation by the American Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation. Instruction and required experience may be obtained in one or more institutions or agencies outside the applying university or college if the program retains accountability for all clinical and nonclinical teaching; and

(3) meet other standards established by law and by the board.

Subd. 2. **Continuing approval.** The board must, through the board's representative, annually survey all midwifery education programs in Minnesota for current accreditation status by the American Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation. If the results of the survey show that a certified midwifery education program meets all standards for continuing accreditation, the board must continue approval of the certified midwifery education program.

Subd. 3. **Loss of approval.** If the board determines that an accredited certified midwifery education program is not maintaining the standards required by the American Commission on Midwifery Education or any successor organization, the board must obtain the defect in writing from the accrediting body. If a program fails to correct the defect to the satisfaction of the accrediting body and the accrediting body revokes the program's accreditation, the board must remove the program from the list of approved certified midwifery education programs.

Subd. 4. **Reinstatement of approval.** The board must reinstate approval of a certified midwifery education program upon submission of satisfactory evidence that the certified midwifery education program of theory and practice meets the standards required by the accrediting body.

Sec. 98. **[148G.13] GROUNDS FOR DISCIPLINARY ACTION.**

Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition the license of any person to practice certified midwifery under this chapter or otherwise discipline a licensee or applicant as described in section 148G.14. The following are grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. In the case of an applicant for licensure, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements;

(2) employing fraud or deceit in procuring or attempting to procure a license to practice certified midwifery;

(3) conviction of a felony or gross misdemeanor reasonably related to the practice of certified midwifery. Conviction, as used in this subdivision, includes a conviction of an offense that if committed in this state would be considered a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned, but the adjudication of guilt is either withheld or not entered;

(4) revocation, suspension, limitation, conditioning, or other disciplinary action against the person's certified midwife credential in another state, territory, or country; failure to report to the board that charges regarding the person's certified midwifery license, certification, or other credential are pending in another state, territory, or country; or failure to report to the board having been refused a license or other credential by another state, territory, or country;

(5) failure or inability to practice as a certified midwife with reasonable skill and safety, or departure from or failure to conform to standards of acceptable and prevailing certified midwifery practice, including failure of a certified midwife to adequately supervise or monitor the performance of acts by any person working at the certified midwife's direction;

(6) engaging in unprofessional conduct, including but not limited to a departure from or failure to conform to statutes relating to certified midwifery practice or to the minimal standards of acceptable and prevailing certified midwifery practice, or engaging in any certified midwifery practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause;

(7) supervision or accepting the supervision of a midwifery function or a prescribed health care function when the acceptance could reasonably be expected to result in unsafe or ineffective patient care;

(8) actual or potential inability to practice certified midwifery with reasonable skill and safety to patients by reason of illness; by the reason of use of alcohol, drugs, chemicals, or any other material; or as a result of any mental or physical condition;

(9) adjudication as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, within or outside of Minnesota;

(10) engaging in any unethical conduct, including but not limited to conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established under this clause;

(11) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, in any verbal behavior that is seductive or sexually demeaning to a patient, or in sexual exploitation of a patient or former patient;

(12) obtaining money, property, or services from a patient, other than reasonable fees for services provided to the patient, through the use of undue influence, harassment, duress, deception, or fraud;

(13) revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(14) engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws;

(15) improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(16) knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of certified midwifery;

(17) violating a rule adopted by the board, an order of the board, a state or federal law relating to the practice of certified midwifery, or a state or federal narcotics or controlled substance law;

(18) knowingly providing false or misleading information to a patient that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo;

(19) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board must investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(20) practicing outside the scope of certified midwifery practice as defined under section 148G.03, subdivision 5;

(21) making a false statement or knowingly providing false information to the board, failing to make reports as required by section 148G.15, or failing to cooperate with an investigation of the board as required by section 148G.17;

(22) engaging in false, fraudulent, deceptive, or misleading advertising;

(23) failure to inform the board of the person's certification or recertification status as a certified midwife;

(24) engaging in certified midwifery practice without a license and current certification or recertification by the American Midwifery Certification Board or any successor organization; or

(25) failure to maintain appropriate professional boundaries with a patient. A certified midwife must not engage in practices that create an unacceptable risk of patient harm or of the impairment of a certified midwife's objectivity or professional judgment. A certified midwife must not act or fail to act in a way that, as judged by a reasonable and prudent certified midwife, inappropriately encourages the patient to relate to the certified midwife outside of the boundaries of the professional relationship or in a way that interferes with the patient's ability to benefit from certified midwife services. A certified midwife must not use the professional relationship with a patient, student, supervisee, or intern to further the certified midwife's personal, emotional, financial, sexual, religious, political, or business benefit or interests.

Subd. 2. **Conviction of a felony-level criminal sexual offense.** (a) Except as provided in paragraph (e), the board must not grant or renew a license to practice certified midwifery to any person who has been convicted on or after August 1, 2014, of any of the provisions of section 609.342, subdivision 1 or 1a; 609.343, subdivision 1 or 1a; 609.344, subdivision

1 or 1a, paragraphs (c) to (g); or 609.345, subdivision 1 or 1a, paragraphs (c) to (g); or a similar statute in another jurisdiction.

(b) A license to practice certified midwifery is automatically revoked if the licensee is convicted of an offense listed in paragraph (a).

(c) A license to practice certified midwifery that has been denied or revoked under this subdivision is not subject to chapter 364.

(d) For purposes of this subdivision, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, unless the court stays imposition or execution of the sentence and final disposition of the case is accomplished at a nonfelony level.

(e) The board may establish criteria whereby an individual convicted of an offense listed in paragraph (a) may become licensed if the criteria:

(1) utilize a rebuttable presumption that the applicant is not suitable for licensing;

(2) provide a standard for overcoming the presumption; and

(3) require that a minimum of ten years has elapsed since the applicant's sentence was discharged.

(f) The board must not consider an application under paragraph (e) if the board determines that the victim involved in the offense was a patient or a client of the applicant at the time of the offense.

Subd. 3. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, clause (3) or (4), or 2, a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same is admissible into evidence without further authentication and constitutes prima facie evidence of the violation concerned.

Subd. 4. **Examination; access to medical data.** (a) If the board has probable cause to believe that grounds for disciplinary action exist under subdivision 1, clause (8) or (9), it may direct the applicant or certified midwife to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this subdivision, when a certified midwife licensed under this chapter is directed in writing by the board to submit to a mental or physical examination or chemical dependency evaluation, that person is considered to have consented and to have waived all objections to admissibility on the grounds of privilege. Failure of the applicant or certified midwife to submit to an examination when directed constitutes an admission of the allegations against the applicant or certified midwife, unless the failure was due to circumstances beyond the person's control, and the board may enter

a default and final order without taking testimony or allowing evidence to be presented. A certified midwife affected under this paragraph must, at reasonable intervals, be given an opportunity to demonstrate that the competent practice of certified midwifery can be resumed with reasonable skill and safety to patients. Neither the record of proceedings nor the orders entered by the board in a proceeding under this paragraph may be used against a certified midwife in any other proceeding.

(b) Notwithstanding sections 13.384, 144.651, and 595.02, or any other law limiting access to medical or other health data, the board may obtain medical data and health records relating to a certified midwife or applicant for a license without that person's consent if the board has probable cause to believe that grounds for disciplinary action exist under subdivision 1, clause (8) or (9). The medical data may be requested from a provider, as defined in section 144.291, subdivision 2; an insurance company; or a government agency, including the Department of Human Services or Direct Care and Treatment. A provider, insurance company, or government agency must comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew or had reason to believe the information was false. Information obtained under this subdivision is classified as private data on individuals as defined in section 13.02.

Sec. 99. **[148G.14] FORMS OF DISCIPLINARY ACTION; AUTOMATIC SUSPENSION; TEMPORARY SUSPENSION; REISSUANCE.**

Subdivision 1. **Forms of disciplinary action.** If the board finds that grounds for disciplinary action exist under section 148G.13, it may take one or more of the following actions:

(1) deny the license application or application for license renewal;

(2) revoke the license;

(3) suspend the license;

(4) impose limitations on the certified midwife's practice of certified midwifery, including but not limited to limitation of scope of practice or the requirement of practice under supervision;

(5) impose conditions on the retention of the license, including but not limited to the imposition of retraining or rehabilitation requirements or the conditioning of continued

practice on demonstration of knowledge or skills by appropriate examination, monitoring, or other review;

(6) impose a civil penalty not exceeding $10,000 for each separate violation. The amount of the civil penalty must be fixed so as to deprive the certified midwife of any economic advantage gained by reason of the violation charged; to reimburse the board for the cost of counsel, investigation, and proceeding; and to discourage repeated violations;

(7) order the certified midwife to provide unremunerated service;

(8) censure or reprimand the certified midwife; or

(9) any other action justified by the facts in the case.

Subd. 2. **Automatic suspension of license.** (a) Unless the board orders otherwise, a license to practice certified midwifery is automatically suspended if:

(1) a guardian of a certified midwife is appointed by order of a court under sections 524.5-101 to 524.5-502;

(2) the certified midwife is committed by order of a court under chapter 253B; or

(3) the certified midwife is determined to be mentally incompetent, mentally ill, chemically dependent, or a person dangerous to the public by a court of competent jurisdiction within or outside of Minnesota.

(b) The license remains suspended until the certified midwife is restored to capacity by a court and, upon petition by the certified midwife, the suspension is terminated by the board after a hearing or upon agreement between the board and the certified midwife.

Subd. 3. **Temporary suspension of license.** In addition to any other remedy provided by law, the board may, through its designated board member under section 214.10, subdivision 2, temporarily suspend the license of a certified midwife without a hearing if the board finds that there is probable cause to believe the certified midwife has violated a statute or rule the board is empowered to enforce and continued practice by the certified midwife would create a serious risk of harm to others. The suspension takes effect upon written notice to the certified midwife, served by first-class mail, specifying the statute or rule violated. The suspension must remain in effect until the board issues a temporary stay of suspension or a final order in the matter after a hearing or upon agreement between the board and the certified midwife. At the time it issues the suspension notice, the board must schedule a disciplinary hearing to be held under the Administrative Procedure Act. The board must provide the certified midwife at least 20 days' notice of any hearing held under

this subdivision. The board must schedule the hearing to begin no later than 30 days after the issuance of the suspension order.

Subd. 4. **Reissuance.** The board may reinstate and reissue a license to practice certified midwifery, but as a condition may impose any disciplinary or corrective measure that it might originally have imposed. Any person whose license has been revoked, suspended, or limited may have the license reinstated and a new license issued when, at the discretion of the board, the action is warranted, provided that the board must require the person to pay the costs of the proceedings resulting in the revocation, suspension, or limitation of the license; the relicensure fee; and the fee for the current licensure period. The cost of proceedings includes but is not limited to the cost paid by the board to the Office of Administrative Hearings and the Office of the Attorney General for legal and investigative services; the costs of a court reporter and witnesses, reproduction of records, board staff time, travel, and expenses; and the costs of board members' per diem reimbursements, travel costs, and expenses.

Sec. 100. **[148G.15] REPORTING OBLIGATIONS.**

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct constituting grounds for discipline under section 148G.13 may report the alleged violation to the board.

Subd. 2. **Institutions.** The chief nursing executive or chief administrative officer of any hospital, clinic, prepaid medical plan, or other health care institution or organization located in Minnesota must report to the board any action taken by the institution or organization or any of its administrators or committees to revoke, suspend, limit, or condition a certified midwife's privilege to practice in the institution or as part of the organization, any denial of privileges, any dismissal from employment, or any other disciplinary action. The institution or organization must also report the resignation of any certified midwife before the conclusion of any disciplinary proceeding or before commencement of formal charges, but after the certified midwife had knowledge that formal charges were contemplated or in preparation. The reporting described by this subdivision is required only if the action pertains to grounds for disciplinary action under section 148G.13.

Subd. 3. **Licensed professionals.** A person licensed by a health-related licensing board as defined in section 214.01, subdivision 2, must report to the board personal knowledge of any conduct the person reasonably believes constitutes grounds for disciplinary action under section 148G.13 by any certified midwife, including conduct indicating that the certified midwife may be incompetent, may have engaged in unprofessional or unethical

conduct, or may be mentally or physically unable to engage safely in the practice of certified midwifery.

Subd. 4. **Insurers.** (a) By the first day of February, May, August, and November each year, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to certified midwives must submit to the board a report concerning any certified midwife against whom a malpractice award has been made or who has been a party to a settlement. The report must contain at least the following information:

(1) the total number of settlements or awards;

(2) the date a settlement or award was made;

(3) the allegations contained in the claim or complaint leading to the settlement or award;

(4) the dollar amount of each malpractice settlement or award and whether that amount was paid as a result of a settlement or of an award; and

(5) the name and address of the practice of the certified midwife against whom an award was made or with whom a settlement was made.

(b) An insurer must also report to the board any information it possesses that tends to substantiate a charge that a certified midwife may have engaged in conduct in violation of this chapter.

Subd. 5. **Courts.** The court administrator of district court or another court of competent jurisdiction must report to the board any judgment or other determination of the court that adjudges or includes a finding that a certified midwife is a person who is mentally ill, mentally incompetent, chemically dependent, dangerous to the public, guilty of a felony or gross misdemeanor, guilty of a violation of federal or state narcotics laws or controlled substances act, guilty of operating a motor vehicle while under the influence of alcohol or a controlled substance, or guilty of an abuse or fraud under Medicare or Medicaid; or if the court appoints a guardian of the certified midwife under sections 524.5-101 to 524.5-502 or commits a certified midwife under chapter 253B.

Subd. 6. **Deadlines; forms.** Reports required by subdivisions 2, 3, and 5 must be submitted no later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required under this section, may require that the reports be submitted on the forms provided, and may adopt rules necessary to ensure prompt and accurate reporting. The board must review all reports, including those submitted after the deadline.

Subd. 7. **Failure to report.** Any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 is subject to civil penalties for failing to report as required by law.

Sec. 101. **[148G.16] IMMUNITY.**

Subdivision 1. **Reporting.** Any person, health care facility, business, or organization is immune from civil liability and criminal prosecution for submitting in good faith a report to the board under section 148G.15 or for otherwise reporting in good faith to the board violations or alleged violations of this chapter. All such reports are investigative data as defined in chapter 13.

Subd. 2. **Investigation.** (a) Members of the board, persons employed by the board or engaged in the investigation of violations and in the preparation and management of charges of violations of this chapter on behalf of the board, or persons participating in the investigation or testifying regarding charges of violations are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

(b) Members of the board and persons employed by the board or engaged in maintaining records and making reports regarding adverse health care events are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

Sec. 102. **[148G.17] CERTIFIED MIDWIFE COOPERATION.**

A certified midwife who is the subject of an investigation by or on behalf of the board must cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation and providing copies of patient or other records in the certified midwife's possession, as reasonably requested by the board, to assist the board in its investigation and to appear at conferences and hearings scheduled by the board. The board must pay for copies requested. If the board does not have written consent from a patient permitting access to the patient's records, the certified midwife must delete any data in the record that identify the patient before providing it to the board. The board must maintain any records obtained pursuant to this section as investigative data under chapter 13. The certified midwife must not be excused from giving testimony or producing any documents, books, records, or correspondence on the grounds of self-incrimination, but the testimony or evidence must not be used against the certified midwife in any criminal case.

Sec. 103. **[148G.18] DISCIPLINARY RECORD ON JUDICIAL REVIEW.**

Upon judicial review of any board disciplinary action taken under this chapter, the reviewing court must seal the administrative record, except for the board's final decision, and must not make the administrative record available to the public.

Sec. 104. **[148G.19] EXEMPTIONS.**

The provisions of this chapter do not prohibit:

(1) the furnishing of certified midwifery assistance in an emergency;

(2) the practice of certified midwifery by any legally qualified certified midwife of another state who is employed by the United States government or any bureau, division, or agency thereof while in the discharge of official duties;

(3) the practice of any profession or occupation licensed by Minnesota, other than certified midwifery, by any person licensed to practice the profession or occupation, or the performance by a person of any acts properly coming within the scope of the profession, occupation, or license;

(4) the practice of traditional midwifery as specified under section 147D.03;

(5) certified midwifery practice by a student practicing under the supervision of an instructor while the student is enrolled in an approved certified midwifery education program; or

(6) certified midwifery practice by a certified midwife licensed in another state, territory, or jurisdiction who is in Minnesota temporarily:

(i) providing continuing or in-service education;

(ii) serving as a guest lecturer;

(iii) presenting at a conference; or

(iv) teaching didactic content via distance education to a student located in Minnesota who is enrolled in a formal, structured course of study, such as a course leading to a higher degree in midwifery.

Sec. 105. **[148G.20] VIOLATIONS; PENALTY.**

Subdivision 1. **Violations described.** It is unlawful for any person, corporation, firm, or association to:

(1) sell or fraudulently obtain or furnish any certified midwifery diploma, license, or record, or aid or abet therein;

(2) practice certified midwifery under cover of any diploma, permit, license, certified midwife credential, or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;

(3) practice certified midwifery unless the person is licensed to do so under this chapter;

(4) use the professional title certified midwife or licensed certified midwife unless licensed to practice certified midwifery under this chapter;

(5) use any abbreviation or other designation tending to imply licensure as a certified midwife unless licensed to practice certified midwifery under this chapter;

(6) practice certified midwifery in a manner prohibited by the board in any limitation of a license issued under this chapter;

(7) practice certified midwifery during the time a license issued under this chapter is suspended or revoked;

(8) knowingly employ persons in the practice of certified midwifery who have not been issued a current license to practice as a certified midwife in this state; or

(9) conduct a certified midwifery program for the education of persons to become certified midwives unless the program has been approved by the board.

Subd. 2. **Penalty.** Any person, corporation, firm, or association violating any provision of subdivision 1 is guilty of a gross misdemeanor and must be punished according to law.

Subd. 3. **Penalty; certified midwives.** In addition to subdivision 2, a person who practices certified midwifery without a current license and certification or recertification, or without current certification or recertification on file with the board, is subject to the applicable penalties in section 148G.11.

Sec. 106. **[148G.21] UNAUTHORIZED PRACTICE OF MIDWIFERY.**

The practice of certified midwifery by any person who is not licensed to practice certified midwifery under this chapter, whose license has been suspended or revoked, or whose national certification credential has expired is inimical to the public health and welfare and constitutes a public nuisance. Upon a complaint being made by the board or any prosecuting officer and upon a proper showing of the facts, the district court of the county where the practice occurred may enjoin such acts and practice. The injunction proceeding is in addition to, and not in lieu of, all other penalties and remedies provided by law.

Sec. 107. Minnesota Statutes 2024, section 150A.105, is amended by adding a subdivision to read:

Subd. 3a. **Collaborative management agreement under armed forces.** (a) While practicing under the auspices of the Minnesota National Guard or any branch of the armed forces, including the Navy, Marines, Army, Coast Guard, or Space Force, the collaborating dentist may be determined by the command structure of the armed service for which the dental therapist is a member assigned or contracted.

(b) A collaborating dentist for a dental therapist when in civilian practice will not be responsible for supervising the dental services performed by the dental therapist while the dental therapist is practicing under the auspices of the armed forces.

Sec. 108. Minnesota Statutes 2024, section 151.01, subdivision 15, is amended to read:

Subd. 15. **Pharmacist intern or intern.** "Pharmacist intern" or "intern" means:

(1) a natural person who has completed college or school of pharmacy orientation or is otherwise enrolled in a doctor of pharmacy program accredited by the Accreditation Council for Pharmacy Education (ACPE) and is satisfactorily progressing toward the degree in pharmacy required for licensure~~, or~~;

(2) a graduate of ~~the University of Minnesota College of Pharmacy, or other pharmacy college approved by the board,~~ a doctor of pharmacy program accredited by ACPE who is registered by the Board of Pharmacy for the purpose of obtaining practical experience as a requirement for licensure as a pharmacist~~, or~~;

(3) a qualified applicant awaiting examination for licensure~~.~~;

(4) a participant in a residency or fellowship program who is not licensed to practice pharmacy in Minnesota but is:

(i) licensed to practice pharmacy in another state; or

(ii) a graduate of a doctor of pharmacy program accredited by ACPE and not registered by the board under clause (2); or

(5) a foreign pharmacy graduate who:

(i) has passed the Foreign Pharmacy Graduate Equivalency Examination;

(ii) is certified by the Foreign Pharmacy Graduate Equivalency Commission; and

(iii) is seeking internship experience in accordance with Minnesota Rules, part 6800.1250.

Sec. 109. Minnesota Statutes 2024, section 151.01, subdivision 23, is amended to read:

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed advanced practice registered nurse, licensed certified midwife, or licensed physician assistant. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe self-administered hormonal contraceptives, nicotine replacement medications, or opiate antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37, subdivision 17.

Sec. 110. Minnesota Statutes 2024, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, $225;

(2) pharmacist licensed by reciprocity, $300;

(3) pharmacy intern, ~~$75~~ $25;

(4) pharmacy technician, $60;

(5) pharmacy, $450;

(6) drug wholesaler, legend drugs only, $5,500;

(7) drug wholesaler, legend and nonlegend drugs, $5,500;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $5,500;

(9) drug wholesaler, medical gases, $5,500 for the first facility and $500 for each additional facility;

(10) third-party logistics provider, $300;

(11) drug manufacturer, nonopiate legend drugs only, $5,500;

(12) drug manufacturer, nonopiate legend and nonlegend drugs, $5,500;

(13) drug manufacturer, nonlegend or veterinary legend drugs, $5,500;

(14) drug manufacturer, medical gases, $5,500 for the first facility and $500 for each additional facility;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, $5,500;

(16) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, $55,500;

(17) medical gas dispenser, $400;

(18) controlled substance researcher, $150; and

(19) pharmacy professional corporation, $150.

Sec. 111. Minnesota Statutes 2024, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, $225;

(2) pharmacy technician, $60;

(3) beginning January 1, 2026, pharmacy intern, $25;

~~(3)~~ (4) pharmacy, $450;

~~(4)~~ (5) drug wholesaler, legend drugs only, $5,500;

~~(5)~~ (6) drug wholesaler, legend and nonlegend drugs, $5,500;

~~(6)~~ (7) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $5,500;

~~(7)~~ (8) drug wholesaler, medical gases, $5,500 for the first facility and $500 for each additional facility;

~~(8)~~ (9) third-party logistics provider, $300;

~~(9)~~ (10) drug manufacturer, nonopiate legend drugs only, $5,500;

~~(10)~~ (11) drug manufacturer, nonopiate legend and nonlegend drugs, $5,500;

~~(11)~~ (12) drug manufacturer, nonlegend, veterinary legend drugs, or both, $5,500;

~~(12)~~ (13) drug manufacturer, medical gases, $5,500 for the first facility and $500 for each additional facility;

~~(13)~~ (14) drug manufacturer, also licensed as a pharmacy in Minnesota, $5,500;

~~(14)~~ (15) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, $55,500;

~~(15)~~ (16) medical gas dispenser, $400;

~~(16)~~ (17) controlled substance researcher, $150; and

~~(17)~~ (18) pharmacy professional corporation, $150.

Sec. 112. Minnesota Statutes 2024, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $250.

(c) A pharmacy intern who has allowed the intern's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $100.

~~(c)~~ (d) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics provider, or a medical gas dispenser who has allowed the license of the establishment to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

~~(d)~~ (e) A controlled substance researcher who has allowed the researcher's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

~~(e)~~ (f) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

Sec. 113. Minnesota Statutes 2024, section 151.101, is amended to read:

151.101 INTERNSHIP.

Subdivision 1. **Registration requirements.** (a) Upon payment of the fee specified in section 151.065, the board may register as an intern any natural persons who have satisfied the board that they are of good moral character, not physically or mentally unfit, and who have successfully completed the educational requirements for intern registration prescribed

by the board. ~~The board shall prescribe standards and requirements for interns, pharmacist-preceptors, and internship training but may not require more than one year of such training.~~

(b) The board in its discretion may accept internship experience obtained in another state provided the internship requirements in such other state are in the opinion of the board equivalent to those herein provided.

Subd. 2. **Renewal requirements.** (a) Beginning January 1, 2026, an intern registration expires on September 30 each year or when the intern receives a pharmacist license, whichever is earlier.

(b) To renew an intern registration, the intern must file an application for renewal and submit the fee established under section 151.065 on or before September 1 each year.

(c) If the board does not receive the intern's registration renewal application on or before September 1 each year, the intern is subject to a late filing fee equal to 50 percent of the renewal fee under section 151.065 in addition to the renewal fee.

(d) An individual who received an intern registration under the criteria in section 151.01, subdivision 15, clause (1), and paid $75 for the individual's application fee between May 1, 2024, and June 30, 2025, is not subject to the $25 renewal fee for the first two renewal cycles following the $75 fee payment.

(e) If an individual is no longer enrolled in a doctor of pharmacy program accredited by the Accreditation Council for Pharmacy Education, the board must terminate that individual's intern registration effective the last date the individual was enrolled in a qualifying program.

(f) The board must not renew an intern registration unless the individual:

(1) has maintained current notices of employment for internship training with the board;

(2) submitted a progress report affidavit of the intern credit hours completed by June 15 each year;

(3) meets all other eligibility criteria for a pharmacist intern; and

(4) demonstrates to the board's satisfaction the individual is in good faith and with reasonable diligence pursuing a degree in pharmacy or is completing a pharmacy residency or fellowship.

(g) An intern whose registration has lapsed may renew the intern registration within one year of expiration, subject to the fees in paragraph (c). An intern whose registration has lapsed for more than one year must meet the registration requirements for an initial intern

applicant in effect at the time the individual applies for reinstatement and pay any fees and late fees in arrears in accordance with section 151.065.

(h) If the board receives a late renewal, reinstatement, or initial intern application from an eligible individual within 90 days before September 30, the board may extend the registration expiration date for that applicant to September 30 of the subsequent calendar year and prorate the application fee accordingly.

Subd. 3. **Internship credit hour requirements.** (a) To apply for licensure as a pharmacist under section 151.10, an individual must complete at least 1,600 intern credit hours under the direction and supervision of a preceptor.

(b) Of the 1,600 credit hours required under this subdivision, an intern may earn:

(1) a maximum of 80 credit hours in the individual's first professional academic year for a structured experience directed by the college of pharmacy that the individual attends and is overseen by college faculty, registered preceptors, or supervising licensed pharmacists;

(2) a maximum of 400 credit hours of concurrent time internship; and

(3) a maximum of 54 credit hours per week that may be earned from more than one site.

Sec. 114. Minnesota Statutes 2024, section 152.12, subdivision 1, is amended to read:

Subdivision 1. **Prescribing, dispensing, administering controlled substances in Schedules II through V.** A licensed doctor of medicine, a doctor of osteopathic medicine, duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a licensed doctor of podiatry, a licensed advanced practice registered nurse, a licensed certified midwife, a licensed physician assistant, or a licensed doctor of optometry limited to Schedules IV and V, and in the course of professional practice only, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, may cause the same to be administered by a nurse, an intern or an assistant under the direction and supervision of the doctor, and may cause a person who is an appropriately certified and licensed health care professional to prescribe and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes.

Sec. 115. **[153.30] FEES.**

Subdivision 1. **Nonrefundable fees.** The fees in this section are nonrefundable.

Subd. 2. **Fee amounts.** The amount of fees must be set by the board so that the total fees collected by the board equals as closely as possible the anticipated expenditures during

the fiscal biennium, as provided in section 16A.1285. Fees must not exceed the following amounts but may be adjusted lower by board action:

(1) application for licensure fee, $1,000;

(2) renewal licensure fee, $1,000;

(3) late renewal fee, $250;

(4) temporary permit fee, $250;

(5) duplicate license fee or duplicate renewal certificate fee, $25;

(6) reinstatement fee, $1,250;

(7) examination administration fee for persons who have not applied for a license or permit, $50;

(8) verification of licensure fee, $50;

(9) label fee, $50;

(10) list of licensees fee, $50; and

(11) copies fee, $0.50 per page.

Subd. 3. **Current fee information.** Information about fees in effect at any time must be available from the board office.

Subd. 4. **Deposit of fees.** The license fees collected under this section must be deposited in the state government special revenue fund.

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

Sec. 116. Minnesota Statutes 2024, section 153B.85, subdivision 1, is amended to read:

Subdivision 1. **Fees.** (a) The application fee for initial licensure shall not exceed $600.

(b) The biennial renewal fee for a license to practice as an orthotist, prosthetist, prosthetist orthotist, or pedorthist shall not exceed $600.

(c) The biennial renewal fee for a license to practice as an assistant or a fitter shall not exceed $300.

(d) The fee for license restoration shall not exceed $600.

(e) The fee for license verification shall not exceed ~~$30~~ $50.

(f) The fee to obtain a list of licensees shall not exceed ~~$25~~ $50.

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

Sec. 117. Minnesota Statutes 2024, section 153B.85, subdivision 3, is amended to read:

Subd. 3. **Late fee.** The fee for late license renewal is the license renewal fee in effect at the time of renewal plus ~~$100~~ $250.

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

Sec. 118. Minnesota Statutes 2024, section 156.015, is amended by adding a subdivision to read:

Subd. 1a. **Nonrefundable fees.** All fees are nonrefundable.

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

Sec. 119. Minnesota Statutes 2024, section 156.015, is amended by adding a subdivision to read:

Subd. 3. **Fee amounts.** Fees must not exceed the following amounts but may be adjusted lower by board action:

(1) initial application fee, $75;

(2) state examination fee, $75;

(3) duplicate license fee, $25;

(4) continuing education sponsor application fee, $75;

(5) mailing list fee, $250;

(6) initial veterinary license fee, $300;

(7) initial veterinary technician fee, $100;

(8) active veterinary renewal fee, $300;

(9) active veterinary technician renewal fee, $100;

(10) inactive veterinary renewal fee, $150;

(11) inactive veterinary technician renewal fee, $50;

(12) institutional license fee, $300;

(13) active late veterinary renewal fee, $150;

(14) active late veterinary technician renewal fee, $50;

(15) inactive late veterinary renewal fee, $100;

(16) inactive late veterinary technician renewal fee, $25; and

(17) institutional late renewal fee, $150.

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

Sec. 120. Minnesota Statutes 2024, section 156.015, is amended by adding a subdivision to read:

Subd. 4. **License verification.** The board may charge a fee not to exceed $25 per license verification to a licensee for verification of licensure status provided to other veterinary licensing boards.

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

Sec. 121. Minnesota Statutes 2024, section 156.015, is amended by adding a subdivision to read:

Subd. 5. **Deposit of fees.** The license fees collected under this section must be deposited in the state government special revenue fund.

Sec. 122. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 28c. **Certified midwifery practice services.** Medical assistance covers services performed by a licensed certified midwife if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the facility payment;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the certified midwife's license as defined under chapter 148G.

Sec. 123. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall renumber Minnesota Statutes, section 148.6408, subdivision 1, as Minnesota Statutes, section 148.6408, subdivision 1b.

(b) The revisor of statutes shall renumber Minnesota Statutes, section 148.6410, subdivision 1, as Minnesota Statutes, section 148.6410, subdivision 1b.

Sec. 124. **REPEALER.**

(a) Minnesota Statutes 2024, sections 148.108, subdivisions 2, 3, and 4; 148.6402, subdivision 22a; 148.6420, subdivisions 2, 3, and 4; 148.6423, subdivisions 4, 5, 7, 8, and 9; 148.6425, subdivision 3; 148.6430; 148.6445, subdivisions 5, 6, and 8; and 156.015, subdivision 1, are repealed.

(b) Minnesota Rules, parts 2500.1150; 2500.2030; 6800.5100, subpart 5; 6800.5400, subparts 5 and 6; 9100.0400, subparts 1 and 3; 9100.0500; and 9100.0600, are repealed.

(c) Minnesota Rules, part 6900.0250, subparts 1 and 2, are repealed.

EFFECTIVE DATE. Paragraphs (a) and (b) are effective July 1, 2025. Paragraph (c) is effective the day following final enactment.

ARTICLE 4
MINNESOTA HEALTH AND EDUCATION FACILITIES AUTHORITY

Section 1. Minnesota Statutes 2024, section 3.732, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** As used in this section and section 3.736 the terms defined in this section have the meanings given them.

(1) "State" includes each of the departments, boards, agencies, commissions, courts, and officers in the executive, legislative, and judicial branches of the state of Minnesota and includes but is not limited to the Housing Finance Agency, the Minnesota Office of Higher Education, the ~~Higher~~ Health and Education Facilities Authority, the Health Technology Advisory Committee, the Armory Building Commission, the Zoological Board, the Department of Iron Range Resources and Rehabilitation, the Minnesota Historical Society, the State Agricultural Society, the University of Minnesota, the Minnesota State Colleges and Universities, state hospitals, and state penal institutions. It does not include a city, town, county, school district, or other local governmental body corporate and politic.

(2) "Employee of the state" means all present or former officers, members, directors, or employees of the state, members of the Minnesota National Guard, members of a bomb disposal unit approved by the commissioner of public safety and employed by a municipality defined in section 466.01 when engaged in the disposal or neutralization of bombs or other similar hazardous explosives, as defined in section 299C.063, outside the jurisdiction of the municipality but within the state, or persons acting on behalf of the state in an official capacity, temporarily or permanently, with or without compensation. It does not include either an independent contractor except, for purposes of this section and section 3.736 only,

a guardian ad litem acting under court appointment, or members of the Minnesota National Guard while engaged in training or duty under United States Code, title 10, or title 32, section 316, 502, 503, 504, or 505, as amended through December 31, 1983. Notwithstanding sections 43A.02 and 611.263, for purposes of this section and section 3.736 only, "employee of the state" includes a district public defender or assistant district public defender in the Second or Fourth Judicial District, a member of the Health Technology Advisory Committee, and any officer, agent, or employee of the state of Wisconsin performing work for the state of Minnesota pursuant to a joint state initiative.

(3) "Scope of office or employment" means that the employee was acting on behalf of the state in the performance of duties or tasks lawfully assigned by competent authority.

(4) "Judicial branch" has the meaning given in section 43A.02, subdivision 25.

Sec. 2. Minnesota Statutes 2024, section 10A.01, subdivision 35, is amended to read:

Subd. 35. **Public official.** "Public official" means any:

(1) member of the legislature;

(2) individual employed by the legislature as secretary of the senate, legislative auditor, director of the Legislative Budget Office, chief clerk of the house of representatives, revisor of statutes, or researcher, legislative analyst, fiscal analyst, or attorney in the Office of Senate Counsel, Research and Fiscal Analysis, House Research, or the House Fiscal Analysis Department;

(3) constitutional officer in the executive branch and the officer's chief administrative deputy;

(4) solicitor general or deputy, assistant, or special assistant attorney general;

(5) commissioner, deputy commissioner, or assistant commissioner of any state department or agency as listed in section 15.01 or 15.06, or the state chief information officer;

(6) member, chief administrative officer, or deputy chief administrative officer of a state board or commission that has either the power to adopt, amend, or repeal rules under chapter 14, or the power to adjudicate contested cases or appeals under chapter 14;

(7) individual employed in the executive branch who is authorized to adopt, amend, or repeal rules under chapter 14 or adjudicate contested cases under chapter 14;

(8) executive director of the State Board of Investment;

(9) deputy of any official listed in clauses (7) and (8);

(10) judge of the Workers' Compensation Court of Appeals;

(11) administrative law judge or compensation judge in the State Office of Administrative Hearings or unemployment law judge in the Department of Employment and Economic Development;

(12) member, regional administrator, division director, general counsel, or operations manager of the Metropolitan Council;

(13) member or chief administrator of a metropolitan agency;

(14) director of the Division of Alcohol and Gambling Enforcement in the Department of Public Safety;

(15) member or executive director of the ~~Higher~~ Health and Education Facilities Authority;

(16) member of the board of directors or president of Enterprise Minnesota, Inc.;

(17) member of the board of directors or executive director of the Minnesota State High School League;

(18) member of the Minnesota Ballpark Authority established in section 473.755;

(19) citizen member of the Legislative-Citizen Commission on Minnesota Resources;

(20) manager of a watershed district, or member of a watershed management organization as defined under section 103B.205, subdivision 13;

(21) supervisor of a soil and water conservation district;

(22) director of Explore Minnesota Tourism;

(23) citizen member of the Lessard-Sams Outdoor Heritage Council established in section 97A.056;

(24) citizen member of the Clean Water Council established in section 114D.30;

(25) member or chief executive of the Minnesota Sports Facilities Authority established in section 473J.07;

(26) district court judge, appeals court judge, or supreme court justice;

(27) county commissioner;

(28) member of the Greater Minnesota Regional Parks and Trails Commission;

(29) member of the Destination Medical Center Corporation established in section 469.41; or

(30) chancellor or member of the Board of Trustees of the Minnesota State Colleges and Universities.

Sec. 3. Minnesota Statutes 2024, section 136A.25, is amended to read:

136A.25 CREATION.

A state agency known as the Minnesota ~~Higher~~ Health and Education Facilities Authority is hereby created.

Sec. 4. Minnesota Statutes 2024, section 136A.26, is amended to read:

136A.26 MEMBERSHIPS; OFFICERS; COMPENSATION; REMOVAL.

Subdivision 1. **Membership.** The Minnesota ~~Higher~~ Health and Education Facilities Authority shall consist of ~~eight~~ nine members appointed by the governor with the advice and consent of the senate, and a representative of the ~~office~~ Office of Higher Education.

All members to be appointed by the governor shall be residents of the state. At least two members must reside outside the metropolitan area as defined in section 473.121, subdivision 2. At least one of the members shall be a person having a favorable reputation for skill, knowledge, and experience in the field of state and municipal finance; ~~and~~ at least one shall be a person having a favorable reputation for skill, knowledge, and experience in the building construction field; ~~and~~ at least one of the members shall be a trustee, director, officer, or employee of an institution of higher education; and at least one of the members shall be a trustee, director, officer, or employee of a health care organization.

Subd. 1a. **Private College Council member.** The president of the Minnesota Private College Council, or the president's designee, shall serve without compensation as an advisory, nonvoting member of the authority.

Subd. 1b. **Nonprofit health care association member.** The chief executive officer of a Minnesota nonprofit membership association whose members are primarily nonprofit health care organizations, or the chief executive officer's designee, shall serve without compensation as an advisory, nonvoting member of the authority. The identity of the Minnesota nonprofit membership association shall be determined and may be changed from time to time by the members of the authority in accordance with and as shall be provided in the bylaws of the authority.

Subd. 2. **Term; compensation; removal.** The membership terms, compensation, removal of members, and filling of vacancies for authority members other than the representative of the office, ~~and~~ the president of the Private College Council, or the chief executive officer of the Minnesota nonprofit membership association described in subdivision 1b shall be as provided in section 15.0575.

Sec. 5. Minnesota Statutes 2024, section 136A.27, is amended to read:

136A.27 POLICY.

It is hereby declared that for the benefit of the people of the state, the increase of their commerce, welfare and prosperity and the improvement of their health and living conditions it is essential that health care organizations in Minnesota be provided with appropriate additional means to establish, acquire, construct, improve, and expand health care facilities in furtherance of their purposes; that this and future generations of youth be given the fullest opportunity to learn and to develop their intellectual and mental capacities; ~~that it is essential~~ that institutions of higher education within the state be provided with appropriate additional means to assist ~~such~~ youth in achieving the required levels of learning and development of their intellectual and mental capacities; and that health care organizations and institutions of higher education be enabled to refinance outstanding indebtedness incurred to provide existing facilities used for ~~such~~ those purposes in order to preserve and enhance the utilization of facilities for purposes of health care and higher education, to extend or adjust maturities in relation to the resources available for their payment, and to save interest costs and thereby reduce health care costs or higher education tuition, fees, and charges~~; and~~. It is hereby further declared that it is the purpose of sections 136A.25 to 136A.42 to provide a measure of assistance and an alternative method to enable health care organizations and institutions of higher education in the state to provide the facilities and structures which are sorely needed to accomplish the purposes of sections 136A.25 to 136A.42, all to the public benefit and good, to the extent and manner provided herein.

Sec. 6. Minnesota Statutes 2024, section 136A.28, is amended to read:

136A.28 DEFINITIONS.

Subdivision 1. **Scope.** In sections 136A.25 to 136A.42, the following words and terms shall, unless the context otherwise requires, have the meanings ascribed to them.

Subd. 1a. **Affiliate.** "Affiliate" means an entity that directly or indirectly controls, is controlled by, or is under common control with another entity. For purposes of this subdivision, "control" means either the power to elect a majority of the members of the

governing body of an entity or the power, whether by contract or otherwise, to direct the management and policies of the entity. Affiliate also means an entity whose business or substantially all of whose property is operated under a lease, management agreement, or operating agreement by another entity, or an entity who operates the business or substantially all of the property of another entity under a lease, management agreement, or operating agreement.

Subd. 2. **Authority.** "Authority" means the ~~Higher~~ Health and Education Facilities Authority created by sections 136A.25 to 136A.42.

Subd. 3. **Project.** "Project" means ~~a structure or structures available for use as a dormitory or other student housing facility, a dining hall, student union, administration building, academic building, library, laboratory, research facility, classroom, athletic facility, health care facility, child care facility, and maintenance, storage, or utility facility and other structures or facilities related thereto or required or useful for the instruction of students or the conducting of research or the operation of an institution of higher education, whether proposed, under construction, or completed, including parking and other facilities or structures essential or convenient for the orderly conduct of such institution for higher education, and shall also include landscaping, site preparation, furniture, equipment and machinery, and other similar items necessary or convenient for the operation of a particular facility or structure in the manner for which its use is intended but shall not include such items as books, fuel, supplies, or other items the costs of which are customarily deemed to result in a current operating charge, and shall~~ a health care facility or an education facility whether proposed, under construction, or completed, and includes land or interests in land, appurtenances, site preparation, landscaping, buildings and structures, systems, fixtures, furniture, machinery, equipment, and parking. Project also includes other structures, facilities, improvements, machinery, equipment, and means of transport of a capital nature that are necessary or convenient for the operation of the facility. Project does not include: (1) any facility used or to be used for sectarian instruction or as a place of religious worship ~~nor~~; (2) any facility which is used or to be used primarily in connection with any part of the program of a school or department of divinity for any religious denomination; or (3) any books, supplies, medicine, medical supplies, fuel, or other items, the cost of which are customarily deemed to result in a current operating charge.

Subd. 4. **Cost.** "Cost," as applied to a project or any portion ~~thereof~~ financed under the provisions of sections 136A.25 to 136A.42, means all or any part of the cost of construction, acquisition, alteration, enlargement, reconstruction and remodeling of a project including all lands, structures, real or personal property, rights, rights-of-way, franchises, easements

and interests acquired or used for or in connection with a project, the cost of demolishing or removing any buildings or structures on land so acquired, including the cost of acquiring any lands to which ~~such~~ the buildings or structures may be moved, the cost of all machinery and equipment, financing charges, interest prior to, during and for a period after completion of ~~such~~ construction and acquisition, provisions for reserves for principal and interest and for extensions, enlargements, additions and improvements, the cost of architectural, engineering, financial and legal services, plans, specifications, studies, surveys, estimates of cost and of revenues, administrative expenses, expenses necessary or incident to determining the feasibility or practicability of constructing the project and ~~such~~ other expenses as may be necessary or incident to the construction and acquisition of the project, the financing of ~~such~~ construction and acquisition and the placing of the project in operation.

Subd. 5. **Bonds.** "Bonds," or "revenue bonds" means revenue bonds of the authority issued under the provisions of sections 136A.25 to 136A.42, including revenue refunding bonds, notwithstanding that the same may be secured by mortgage or the full faith and credit of a participating institution ~~for higher education~~ or any other lawfully pledged security of a participating institution ~~for higher education~~.

Subd. 6. **Institution of higher education.** "Institution of higher education" means a nonprofit educational institution within the state authorized to provide a program of education beyond the high school level.

Subd. 6a. **Health care organization.** (a) "Health care organization" means a nonprofit organization located within the state and authorized by law to operate a nonprofit health care facility in the state. Health care organization also means a nonprofit affiliate of a health care organization as defined under this paragraph, provided the affiliate is located within the state or within a state that is geographically contiguous to Minnesota.

(b) Health care organization also means a nonprofit organization located in another state that is geographically contiguous to Minnesota and authorized by law to operate a nonprofit health care facility in that state, provided that the nonprofit organization located in the contiguous state is an affiliate of a health care organization located in Minnesota.

Subd. 6b. **Education facility.** "Education facility" means a structure or structures available for use as a dormitory or other student housing facility, dining hall, student union, administration building, academic building, library, laboratory, research facility, classroom, athletic facility, student health care facility, or child care facility, and includes other facilities or structures related to the essential or convenient orderly conduct of an institution of higher education.

Subd. 6c. **Health care facility.** (a) "Health care facility" means a structure or structures available for use in Minnesota as a hospital, clinic, psychiatric residential treatment facility, birth center, outpatient surgical center, comprehensive outpatient rehabilitation facility, outpatient physical therapy or speech pathology facility, end-stage renal dialysis facility, medical laboratory, pharmacy, radiation therapy facility, diagnostic imaging facility, medical office building, residence for nurses or interns, nursing home, boarding care home, assisted living facility, residential hospice, intermediate care facility for persons with developmental disabilities, supervised living facility, housing with services establishment, board and lodging establishment with special services, adult day care center, day services facility, prescribed pediatric extended care facility, community residential setting, adult foster home, or other facility related to medical or health care research, or the delivery or administration of health care services and includes other structures or facilities related to the essential or convenient orderly conduct of a health care organization.

(b) Health care facility also means a facility in a state that is geographically contiguous to Minnesota operated by a health care organization that corresponds by purpose, function, or use with a facility listed in paragraph (a).

Subd. 7. **Participating institution ~~of higher education~~.** "Participating institution ~~of higher education~~" means a health care organization or an institution of higher education that, under the provisions of sections 136A.25 to 136A.42, undertakes the financing and construction or acquisition of a project or undertakes the refunding or refinancing of obligations or of a mortgage or of advances as provided in sections 136A.25 to 136A.42. Community colleges and technical colleges may be considered participating institutions ~~of higher education~~ for the purpose of financing and constructing child care facilities and parking facilities.

Sec. 7. Minnesota Statutes 2024, section 136A.29, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** The purpose of the authority shall be to assist health care organizations and institutions of higher education in the construction, financing, and refinancing of projects. The exercise by the authority of the powers conferred by sections 136A.25 to 136A.42, shall be deemed and held to be the performance of an essential public function. For the purpose of sections 136A.25 to 136A.42, the authority shall have the powers and duties set forth in subdivisions 2 to 23.

Sec. 8. Minnesota Statutes 2024, section 136A.29, subdivision 3, is amended to read:

Subd. 3. **Employees; office space.** The authority is authorized and empowered to appoint and employ employees as it may deem necessary to carry out its duties, determine the title of the employees so employed, and fix the salary of ~~said~~ the employees. Employees of the authority shall participate in retirement and other benefits in the same manner that employees in the ~~unclassified service of the office~~ managerial plan under section 43A.18, subdivision 3, participate. The authority may maintain an office space as it may designate.

Sec. 9. Minnesota Statutes 2024, section 136A.29, subdivision 6, is amended to read:

Subd. 6. **Projects; generally.** (a) The authority is authorized and empowered to determine the location and character of any project to be financed under the provisions of sections 136A.25 to 136A.42, and to construct, reconstruct, remodel, maintain, manage, enlarge, alter, add to, repair, operate, lease, as lessee or lessor, and regulate the same, to enter into contracts for any or all of ~~such~~ these purposes, to enter into contracts for the management and operation of a project, and to designate a participating institution ~~of higher education~~ as its agent to determine the location and character of a project undertaken by ~~such~~ a participating institution ~~of higher education~~ under the provisions of sections 136A.25 to 136A.42 and as the agent of the authority, to construct, reconstruct, remodel, maintain, manage, enlarge, alter, add to, repair, operate, lease, as lessee or lessor, and regulate the same, and as the agent of the authority, to enter into contracts for any or all of ~~such~~ these purposes, including contracts for the management and operation of ~~such~~ the project.

(b) Notwithstanding paragraph (a), a project involving a health care facility in Minnesota financed under sections 136A.25 to 136A.42 must comply with all applicable requirements in state law related to authorizing construction of or modifications to a health care facility, including the requirements in sections 144.5509, 144.551, 144A.071, and 252.291.

(c) Contracts of the authority or of a participating institution ~~of higher education~~ to acquire or to construct, reconstruct, remodel, maintain, enlarge, alter, add to, or repair projects shall not be subject to the provisions of chapter 16C or section 574.26, or any other public contract or competitive bid law.

Sec. 10. Minnesota Statutes 2024, section 136A.29, subdivision 9, is amended to read:

Subd. 9. **Revenue bonds; limit.** (a) The authority is authorized and empowered to issue revenue bonds whose aggregate principal amount at any time shall not exceed ~~$2,000,000,000~~ $5,000,000,000 and to issue notes, bond anticipation notes, and revenue refunding bonds of the authority under the provisions of sections 136A.25 to 136A.42, to provide funds for

acquiring, constructing, reconstructing, enlarging, remodeling, renovating, improving, furnishing, or equipping one or more projects or parts thereof.

(b) Of the $5,000,000,000 limit in paragraph (a), the aggregate principal amount used to fund education facilities may not exceed $2,250,000,000 at any time and the aggregate principal amount used to fund health care facilities may not exceed $2,750,000,000 at any time.

Sec. 11. Minnesota Statutes 2024, section 136A.29, subdivision 10, is amended to read:

Subd. 10. **Revenue bonds; issuance, purpose, conditions.** The authority is authorized and empowered to issue revenue bonds to acquire projects from or to make loans to participating institutions ~~of higher education~~ and thereby refinance outstanding indebtedness incurred by participating institutions ~~of higher education~~ to provide funds for the acquisition, construction or improvement of a facility before or after the enactment of sections 136A.25 to 136A.42, but otherwise eligible to be and being a project thereunder, whenever the authority finds that ~~such~~ the refinancing will enhance or preserve ~~such~~ the participating institutions and ~~such~~ the facilities or utilization ~~thereof~~ that is for health care or educational purposes or extend or adjust maturities to correspond to the resources available for their payment, or reduce charges or fees imposed on patients or occupants, or the tuition, charges, or fees imposed on students for the use or occupancy of the facilities of ~~such~~ the participating institutions ~~of higher education~~ or costs met by federal or state public funds, or enhance or preserve health care or educational programs and research or the acquisition or improvement of other facilities eligible to be a project or part thereof by the participating institution ~~of higher education~~. The amount of revenue bonds to be issued to refinance outstanding indebtedness of a participating institution ~~of higher education~~ shall not exceed the lesser of (a) the fair value of the project to be acquired by the authority from the institution or mortgaged to the authority by the institution or (b) the amount of the outstanding indebtedness including any premium thereon and any interest accrued or to accrue to the date of redemption and any legal, fiscal and related costs in connection with ~~such~~ the refinancing and reasonable reserves, as determined by the authority. The provisions of this subdivision do not prohibit the authority from issuing revenue bonds within and charged against the limitations provided in subdivision 9 to provide funds for improvements, alteration, renovation, or extension of the project refinanced.

Sec. 12. Minnesota Statutes 2024, section 136A.29, subdivision 14, is amended to read:

Subd. 14. **Rules for use of projects.** The authority is authorized and empowered to establish rules for the use of a project or any portion thereof and to designate a participating institution ~~of higher education~~ as its agent to establish rules for the use of a project undertaken for ~~such~~ a participating institution ~~of higher education~~.

Sec. 13. Minnesota Statutes 2024, section 136A.29, subdivision 19, is amended to read:

Subd. 19. **Surety.** Before the issuance of any revenue bonds under the provisions of sections 136A.25 to 136A.42, any member or officer of the authority authorized by resolution of the authority to handle funds or sign checks of the authority shall be covered under a surety or fidelity bond in an amount to be determined by the authority. Each ~~such~~ bond shall be conditioned upon the faithful performance of the duties of the office of the member or officer~~,~~ and shall be executed by a surety company authorized to transact business in the state of Minnesota as surety. The cost of each ~~such~~ bond shall be paid by the authority.

Sec. 14. Minnesota Statutes 2024, section 136A.29, subdivision 20, is amended to read:

Subd. 20. **Sale, lease, and disposal of property.** The authority is authorized and empowered to sell, lease, release, or otherwise dispose of real and personal property or interests therein, or a combination thereof, acquired by the authority under authority of sections 136A.25 to 136A.42 and no longer needed for the purposes of ~~such~~ this chapter or of the authority, and grant ~~such~~ easements and other rights in, over, under, or across a project as will not interfere with its use of ~~such~~ the property. ~~Such~~ The sale, lease, release, disposition, or grant may be made without competitive bidding and in ~~such~~ the manner and for such consideration as the authority in its judgment deems appropriate.

Sec. 15. Minnesota Statutes 2024, section 136A.29, subdivision 21, is amended to read:

Subd. 21. **Loans.** The authority is authorized and empowered to make loans to any participating institution ~~of higher education~~ for the cost of a project in accordance with an agreement between the authority and the participating institution ~~of higher education;~~, provided that no ~~such~~ loan shall exceed the total cost of the project as determined by the participating institution ~~of higher education~~ and approved by the authority.

Sec. 16. Minnesota Statutes 2024, section 136A.29, subdivision 22, is amended to read:

Subd. 22. **Costs, expenses, and other charges.** The authority is authorized and empowered to charge to and apportion among participating institutions ~~of higher education~~

its administrative costs and expenses incurred in the exercise of the powers and duties conferred by sections 136A.25 to 136A.42 in the manner as the authority in its judgment deems appropriate.

Sec. 17. Minnesota Statutes 2024, section 136A.29, is amended by adding a subdivision to read:

Subd. 24. **Determination of affiliate status.** The authority is authorized and empowered to determine whether an entity is an affiliate as defined in section 136A.28, subdivision 1a. A determination by the authority of affiliate status shall be deemed conclusive for the purposes of sections 136A.25 to 136A.42.

Sec. 18. Minnesota Statutes 2024, section 136A.32, subdivision 1, is amended to read:

Subdivision 1. **Bonds; generally.** (a) The authority may from time to time issue revenue bonds for purposes of sections 136A.25 to 136A.42, and all ~~such~~ revenue bonds, notes, bond anticipation notes or other obligations of the authority issued pursuant to sections 136A.25 to 136A.42 shall be and are hereby declared to be negotiable for all purposes notwithstanding their payment from a limited source and without regard to any other law or laws. In anticipation of the sale of ~~such~~ revenue bonds, the authority may issue negotiable bond anticipation notes and may renew the same from time to time, but the maximum maturity of any ~~such~~ note, including renewals ~~thereof~~, shall not exceed five years from the date of issue of the original note. ~~Such~~ Notes shall be paid from any revenues of the authority available therefor and not otherwise pledged, or from the proceeds of sale of the revenue bonds of the authority in anticipation of which they were issued. The notes shall be issued in the same manner as the revenue bonds. ~~Such~~ The notes and the resolution or resolutions authorizing the same may contain any provisions, conditions or limitations which a bond resolution or the authority may contain.

(b) Before issuing revenue bonds, notes, or other obligations under paragraph (a) on behalf of a health care organization to finance health care facilities, the authority must obtain consent by resolution from each city or town where the project is located, except that consent need not be obtained in the case of a city or town with a population of less than 100,000. The consent by resolution requirement does not apply to financing under paragraph (a) on behalf of a participating institution that is primarily an institution of higher education.

Sec. 19. Minnesota Statutes 2024, section 136A.32, subdivision 4, is amended to read:

Subd. 4. **Provisions of resolution authorizing bonds.** Any resolution or resolutions authorizing any revenue bonds or any issue of revenue bonds may contain provisions, which shall be a part of the contract with the holders of the revenue bonds to be authorized, as to:

(1) pledging all or any part of the revenues of a project or projects, any revenue producing contract or contracts made by the authority with ~~any individual partnership, corporation or association or other body~~ one or more partnerships, corporations or associations, or other bodies, public or private, to secure the payment of the revenue bonds or of any particular issue of revenue bonds, subject to ~~such~~ agreements with bondholders as may then exist;

(2) the rentals, fees and other charges to be charged, and the amounts to be raised in each year thereby, and the use and disposition of the revenues;

(3) the setting aside of reserves or sinking funds, and the regulation and disposition ~~thereof~~ of them;

(4) limitations on the right of the authority or its agent to restrict and regulate the use of the project;

(5) limitations on the purpose to which the proceeds of sale of any issue of revenue bonds then or thereafter to be issued may be applied and pledging ~~such~~ the proceeds to secure the payment of the revenue bonds or any issue of the revenue bonds;

(6) limitations on the issuance of additional bonds, the terms upon which additional bonds may be issued and secured and the refunding of outstanding bonds;

(7) the procedure, if any, by which the terms of any contract with bondholders may be amended or abrogated, the amount of bonds the holders of which must consent ~~thereto~~ to, and the manner in which ~~such~~ consent may be given;

(8) limitations on the amount of moneys derived from the project to be expended for operating, administrative or other expenses of the authority;

(9) defining the acts or omissions to act which shall constitute a default in the duties of the authority to holders of its obligations and providing the rights and remedies of ~~such~~ the holders in the event of a default; or

(10) the mortgaging of a project and the site thereof for the purpose of securing the bondholders.

Sec. 20. Minnesota Statutes 2024, section 136A.32, is amended by adding a subdivision to read:

Subd. 4a. **Health care certification.** Health care organizations must provide the authority with a signed certificate from the health care organization stating that so long as authority financing for the health care organization remains outstanding, none of the proceeds of the bonds to the health care organization may be directly or indirectly used to benefit a private party or private equity-funded entity.

Sec. 21. Minnesota Statutes 2024, section 136A.33, is amended to read:

136A.33 TRUST AGREEMENT.

In the discretion of the authority any revenue bonds issued under the provisions of sections 136A.25 to 136A.42, may be secured by a trust agreement by and between the authority and a corporate trustee or trustees, which may be any trust company or bank having the powers of a trust company within the state. ~~Such~~ The trust agreement or the resolution providing for the issuance of ~~such~~ revenue bonds may pledge or assign the revenues to be received or proceeds of any contract or contracts pledged and may convey or mortgage the project or any portion ~~thereof~~ of the project. ~~Such~~ The trust agreement or resolution providing for the issuance of ~~such~~ revenue bonds may contain ~~such~~ provisions for protecting and enforcing the rights and remedies of the bondholders as may be reasonable and proper and not in violation of laws, including ~~particularly such~~ particular provisions ~~as have hereinabove~~ that have been specifically authorized to be included in any resolution or resolutions of the authority authorizing revenue bonds ~~thereof~~. Any bank or trust company incorporated under the laws of the state ~~which~~ that may act as depository of the proceeds of bonds or of revenues or other moneys may furnish ~~such~~ indemnifying bonds or ~~pledges such~~ pledge securities as may be required by the authority. Any ~~such~~ trust agreement may set forth the rights and remedies of the bondholders and of the trustee or trustees and may restrict the individual right of action by bondholders. In addition to the foregoing, any ~~such~~ trust agreement or resolution may contain ~~such~~ other provisions as the authority may deem reasonable and proper for the security of the bondholders. All expenses incurred in carrying out the provisions of ~~such~~ the trust agreement or resolution may be treated as a part of the cost of the operation of a project.

Sec. 22. Minnesota Statutes 2024, section 136A.34, subdivision 3, is amended to read:

Subd. 3. **Investment.** Any ~~such~~ escrowed proceeds, pending ~~such~~ use, may be invested and reinvested in direct obligations of the United States of America, or in certificates of

deposit or time deposits secured by direct obligations of the United States of America, or in shares or units in any money market mutual fund whose investment portfolio consists solely of direct obligations of the United States of America, maturing at ~~such~~ a time or times as shall be appropriate to assure the prompt payment, as to principal, interest and redemption premium, if any, of the outstanding revenue bonds to be so refunded. The interest, income and profits, if any, earned or realized on any ~~such~~ investment may also be applied to the payment of the outstanding revenue bonds to be so refunded. After the terms of the escrow have been fully satisfied and carried out, any balance of ~~such~~ the proceeds and interest, income and profits, if any, earned or realized on the investments ~~thereof~~ may be returned to the authority for use by it in any lawful manner.

Sec. 23. Minnesota Statutes 2024, section 136A.34, subdivision 4, is amended to read:

Subd. 4. **Additional purpose; improvements.** The portion of the proceeds of any ~~such~~ revenue bonds issued for the additional purpose of paying all or any part of the cost of constructing and acquiring additions, improvements, extensions or enlargements of a project may be invested or deposited ~~in time deposits~~ as provided in section 136A.32, subdivision 7.

Sec. 24. Minnesota Statutes 2024, section 136A.36, is amended to read:

136A.36 REVENUES.

The authority may fix, revise, charge and collect rates, rents, fees and charges for the use of and for the services furnished or to be furnished by each project and ~~to~~ may contract with any person, partnership, association or corporation, or other body, public or private, in respect thereof. ~~Such~~ The rates, rents, fees, and charges may vary between projects involving an education facility and projects involving a health care facility and shall be fixed and adjusted in respect of the aggregate of rates, rents, fees, and charges from ~~such~~ the project so as to provide funds sufficient with other revenues, if any:

(1) to pay the cost of maintaining, repairing and operating the project and each and every portion ~~thereof~~ of the project, to the extent that the payment of ~~such~~ the cost has not otherwise been adequately provided for;

(2) to pay the principal of and the interest on outstanding revenue bonds of the authority issued in respect of ~~such~~ the project as the same shall become due and payable; and

(3) to create and maintain reserves required or provided for in any resolution authorizing, or trust agreement securing, ~~such~~ revenue bonds of the authority. ~~Such~~ The rates, rents, fees

and charges shall not be subject to supervision or regulation by any department, commission, board, body, bureau or agency of this state other than the authority. A sufficient amount of the revenues derived in respect of a project, except ~~such~~ part of ~~such~~ the revenues as may be necessary to pay the cost of maintenance, repair and operation and to provide reserves and for renewals, replacements, extensions, enlargements and improvements as may be provided for in the resolution authorizing the issuance of any revenue bonds of the authority or in the trust agreement securing the same, shall be set aside at ~~such~~ regular intervals as may be provided in ~~such~~ the resolution or trust agreement in a sinking or other similar fund ~~which~~ that is hereby pledged to, and charged with, the payment of the principal of and the interest on ~~such~~ revenue bonds as the same shall become due, and the redemption price or the purchase price of bonds retired by call or purchase as therein provided. ~~Such~~ The pledge shall be valid and binding from the time when the pledge is made; the rates, rents, fees and charges and other revenues or other moneys so pledged and thereafter received by the authority shall immediately be subject to the lien of ~~such~~ the pledge without physical delivery ~~thereof~~ or further act, and the lien of any ~~such~~ pledge shall be valid and binding as against all parties having claims of any kind against the authority, irrespective of whether ~~such~~ the parties have notice ~~thereof~~ of the pledge. Neither the resolution nor any trust agreement by which a pledge is created need be filed or recorded except in the records of the authority. The use and disposition of moneys to the credit of ~~such~~ a sinking or other similar fund shall be subject to the provisions of the resolution authorizing the issuance of ~~such~~ bonds or of ~~such~~ a trust agreement. Except as may otherwise be provided in ~~such~~ the resolution or ~~such~~ trust agreement, ~~such~~ the sinking or other similar fund shall be a fund for all ~~such~~ revenue bonds issued to finance a project or projects at one or more participating institutions ~~of higher education~~ without distinction or priority of one over another; provided the authority in any ~~such~~ resolution or trust agreement may provide that ~~such~~ the sinking or other similar fund shall be the fund for a particular project at ~~an~~ a participating institution ~~of higher education~~ and for the revenue bonds issued to finance a particular project and may, additionally, permit and provide for the issuance of revenue bonds having a subordinate lien in respect of the security herein authorized to other revenue bonds of the authority and, in such case, the authority may create separate or other similar funds in respect of ~~such~~ the subordinate lien bonds.

Sec. 25. Minnesota Statutes 2024, section 136A.38, is amended to read:

136A.38 BONDS ELIGIBLE FOR INVESTMENT.

Bonds issued by the authority under the provisions of sections 136A.25 to 136A.42, are hereby made securities in which all public officers and public bodies of the state and its

political subdivisions, all insurance companies, trust companies, banking associations, investment companies, executors, administrators, trustees and other fiduciaries may properly and legally invest funds, including capital in their control or belonging to them; it being the purpose of this section to authorize the investment in ~~such~~ bonds of all sinking, insurance, retirement, compensation, pension and trust funds, whether owned or controlled by private or public persons or officers; provided, however, that nothing contained in this section may be construed as relieving any person, firm, or corporation from any duty of exercising due care in selecting securities for purchase or investment; and provide further, that in no event shall assets of pension funds of public employees of the state of Minnesota or any of its agencies, boards or subdivisions, whether publicly or privately administered, be invested in bonds issued under the provisions of sections 136A.25 to 136A.42. ~~Such~~ The bonds are hereby constituted "authorized securities" within the meaning and for the purposes of Minnesota Statutes 1969, section 50.14. ~~Such~~ The bonds are hereby made securities ~~which~~ that may properly and legally be deposited with and received by any state or municipal officer or any agency or political subdivision of the state for any purpose for which the deposit of bonds or obligations of the state now or may hereafter be authorized by law.

Sec. 26. Minnesota Statutes 2024, section 136A.41, is amended to read:

136A.41 CONFLICT OF INTEREST.

Notwithstanding any other law to the contrary it shall not be or constitute a conflict of interest for a trustee, director, officer or employee of any participating institution ~~of higher education~~, financial institution, investment banking firm, brokerage firm, commercial bank or trust company, architecture firm, insurance company, construction company, or any other firm, person or corporation to serve as a member of the authority, provided ~~such~~ the trustee, director, officer or employee shall abstain from deliberation, action and vote by the authority in each instance where the business affiliation of any ~~such~~ trustee, director, officer or employee is involved.

Sec. 27. Minnesota Statutes 2024, section 136A.42, is amended to read:

136A.42 ANNUAL REPORT.

The authority shall keep an accurate account of all of its activities and all of its receipts and expenditures ~~and shall annually report to the office~~. Each year, the authority shall submit to the Minnesota Historical Society and the Legislative Reference Library a report of the authority's activities in the previous year, including all financial activities.

Sec. 28. Minnesota Statutes 2024, section 136F.67, subdivision 1, is amended to read:

Subdivision 1. **Authorization.** A technical college or a community college must not seek financing for child care facilities or parking facilities through the ~~Higher~~ Health and Education Facilities Authority, as provided in section 136A.28, subdivision 7, without the explicit authorization of the board.

Sec. 29. Minnesota Statutes 2024, section 354B.20, subdivision 7, is amended to read:

Subd. 7. **Employing unit.** "Employing unit," if the agency employs any persons covered by the individual retirement account plan under section 354B.211, means:

(1) the board;

(2) the Minnesota Office of Higher Education; and

(3) the ~~Higher~~ Health and Education Facilities Authority.

Sec. 30. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber the law establishing and governing the Minnesota Higher Education Facilities Authority, renamed the Minnesota Health and Education Facilities Authority in this act, as Minnesota Statutes, chapter 15D, coded in Minnesota Statutes, sections 136A.25 to 136A.42, as amended or repealed in this act. The revisor of statutes shall also duplicate any required definitions from Minnesota Statutes, chapter 136A, revise any statutory cross-references consistent with the recoding, and report the history in Minnesota Statutes, chapter 15D. The revisor of statutes shall change "Minnesota Higher Education Facilities Authority" to "Minnesota Health and Higher Education Facilities Authority" where it appears in Minnesota Statutes.

Sec. 31. **REPEALER.**

Minnesota Statutes 2024, section 136A.29, subdivision 4, is repealed.

ARTICLE 5
PHARMACY BENEFITS

Section 1. **[62Q.83] FORMULARY CHANGES.**

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

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee" has the meaning given in section 62Q.01, subdivision 2b.

(d) "Formulary" means a current list of covered prescription drug products that is subject to periodic review and update.

(e) "Health plan" has the meaning given in section 62Q.01, subdivision 3.

(f) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision 15.

(g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Formulary changes.** (a) Except as provided in paragraphs (b) and (c), a health plan must not, with respect to an enrollee who was previously prescribed the drug during the plan year, remove a drug from the health plan's formulary or place a drug in a benefit category that increases the enrollee's cost for the duration of the enrollee's plan year.

(b) Paragraph (a) does not apply if a health plan changes the health plan's formulary:

(1) for a drug that has been deemed unsafe by the United States Food and Drug Administration (FDA);

(2) for a drug that has been withdrawn by the FDA or the drug manufacturer; or

(3) when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes with respect to a drug's use for reasons related to previously unknown and imminent patient harm.

(c) Paragraph (a) does not apply if a health plan removes a brand name drug from the health plan's formulary or places a brand name drug in a benefit category that increases the enrollee's cost if the health plan:

(1) adds to the health plan's formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at the same or lower cost to the enrollee; and

(2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed

by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, a physician assistant, or an advanced practice registered nurse employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply unless authorized by the commissioner or as provided in paragraph (h) or the drug appears on the 90-day supply list published by the commissioner. The 90-day supply list shall be published by the commissioner on the department's website. The commissioner may add to, delete from, and otherwise modify the 90-day supply list after providing public notice and the opportunity for a 15-day public comment period. The 90-day supply list may include cost-effective generic drugs and shall not include controlled substances.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A

pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

(h) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration for which to prescribe the prescription contraceptives, up to 12 months. For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact. For purposes of this paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

(i) Notwithstanding a removal of a drug from the drug formulary under subdivision 13d, except as provided in paragraphs (j) and (k), medical assistance covers a drug, with respect to an enrollee who was previously prescribed the drug during the calendar year when the drug was on the formulary, at the same level until January 1 of the calendar year following the year in which the commissioner removed the drug from the formulary.

(j) Paragraph (i) does not apply if the commissioner changes the drug formulary:

(1) for a drug that has been deemed unsafe by the United States Food and Drug Administration (FDA);

(2) for a drug that has been withdrawn by the FDA or the drug manufacturer; or

(3) when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes with respect to a drug's use for reasons related to previously unknown and imminent patient harm.

(k) Paragraph (i) does not apply if the commissioner removes a brand name drug from the formulary if the commissioner:

(1) adds to the formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at the same or lower cost to the enrollee; and

(2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

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

Sec. 3. Minnesota Statutes 2024, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in

section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; at least two consumer representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services or have a personal interest in a pharmaceutical company, pharmacy benefits manager, health plan company, or their affiliate organizations, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. For the purposes of this subdivision, "personal interest" means that a person owns at least five percent of the voting interest or equity interest in the entity, the equity interest owned by a person represents at least five percent of that person's net worth, or more than five percent of a person's gross income for the preceding year was derived from the entity. A committee member must notify the committee of any potential conflict of interest and recuse themselves from any communications, discussion, or vote on any matter where a conflict of interest exists. A conflict of interest alone, without a personal interest, does not preclude an applicant from serving as a member of the Formulary Committee. Members may be removed from the committee for cause after a recommendation for removal by a majority of the committee membership. For the purposes of this subdivision, "cause" does not include offering a differing or dissenting clinical opinion on a drug or drug class. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed twice by the commissioner. The committee members shall vote on a chair and vice chair from among their membership. The chair shall preside over all committee meetings, and the vice chair shall preside over the meetings if the chair is not present. The Formulary Committee shall meet at least three times per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee expires June 30, ~~2027~~ 2029. The Formulary Committee is subject to the Open Meeting Law under chapter 13D. For purposes of establishing a quorum to transact business, vacant committee member positions do not count in the calculation as long as at least 60 percent of the committee member positions are filled.

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

Sec. 4. Minnesota Statutes 2024, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

(3) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

(4) drugs or active pharmaceutical ingredients for which medical value has not been established;

(5) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act; and

(6) medical cannabis flower as defined in section 342.01, subdivision 54, or medical cannabinoid products as defined in section 342.01, subdivision 52.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

(d) Within ten calendar days of any commissioner determination to change the drug formulary, the commissioner must provide written notice to all enrollees affected by the change. The notice must include a description of the change, the reason for the change, and the date the change will become effective.

(e) By January 15, 2026, and annually thereafter, the commissioner of human services must provide a report with data and information related to the effects on enrollees of drug formulary changes made in the prior calendar year to the chairs and ranking minority

members of the legislative committees with jurisdiction over health and human services policy and finance. The report must include but is not limited to data and information on:

(1) the number of times the formulary was changed;

(2) the reasons for the formulary changes and how frequently the formulary was changed for each reason;

(3) the drugs that were removed from the formulary;

(4) for each drug that was removed from the formulary, the number of enrollees who were prescribed that drug when it was removed;

(5) for each drug that was removed from the formulary, whether a therapeutically equivalent drug was added;

(6) the drugs that were added to the formulary;

(7) the fiscal impacts to the Department of Human Services resulting from the changes to the formulary; and

(8) enrollee populations or medical conditions disproportionately affected by the formulary changes.

Sec. 5. Minnesota Statutes 2024, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain, unless the prescription savings club or prescription discount club is one in which an individual pays a recurring monthly access fee for unlimited access to a defined list of drugs for which the pharmacy does not bill the member or a payer on a per-standard-transaction basis. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $11.55 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall

be $11.55 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $11.55 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The ingredient cost for a drug is the lower of the National Average Drug Acquisition Cost (NADAC) ~~shall be used to determine the ingredient cost of a drug~~, the Minnesota actual acquisition cost (MNAAC) as defined in paragraph (i), or the maximum allowable cost. For drugs for which a NADAC, a MNAAC, or a maximum allowable cost is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be ~~either~~ the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration ~~or~~, the NADAC, the MNAAC, or the maximum allowable cost, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a ~~multisource~~ drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the lesser of the NADAC of the generic product, the MNAAC of the generic product, or the maximum allowable cost of the generic product established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2. If prior authorization is granted, the ingredient cost shall be the lesser of the NADAC of the brand name product, the MNAAC of the brand name product, or the maximum allowable cost of the brand name product. A generic product includes a generic drug, an authorized generic drug, and a biosimilar biological product as defined in Code of Federal Regulations, title 42, section 423.4. A brand name product includes a brand name drug, a brand name biological product, and an unbranded biological product as defined in Code of Federal Regulations, title 42, section 423.4.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the ~~specialty pharmacy rate~~ MNAAC, or the maximum allowable cost set by the commissioner. If the average sales price ~~is~~, the MNAAC, and the maximum allowable cost are unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider~~,~~ or the wholesale acquisition cost~~, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner~~. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

~~(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the~~

~~commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.~~

~~(g)~~ (f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

~~(h)~~ (g) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every ~~three~~ two years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section 256.01, subdivision 42, this paragraph does not expire.

~~(i)~~ (h) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and ~~(f)~~ (e) by ~~1.8 percent~~ the amount of the wholesale drug distributor tax for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

(i) The commissioner shall contract with a vendor to create MNAAC through a periodic survey of enrolled pharmacy providers. Each pharmacy enrolled with the department to dispense outpatient prescription drugs must respond to the periodic surveys. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The current MNAAC rates must be publicly available on the department's or vendor's website. The commissioner must require that the MNAAC is measured and calculated at least quarterly, but the MNAAC can be measured and calculated more frequently. The commissioner must ensure that the vendor has an appeal process available to providers for the time between the measurement and calculation of the periodically updated MNAAC rates if price fluctuations result in a MNAAC that is lower than the price at which enrolled providers can purchase a drug. Establishment of the MNAAC and survey reporting requirements shall not be subject to the requirements of the Administrative Procedure Act. Data provided by pharmacies for the measurement and calculation of the MNAAC are nonpublic data as defined in section 13.02, subdivision 9.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

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

Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients of public assistance for which payment is made from medical assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the individual or entity is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct

errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which an individual or entity could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph ~~(h)~~ (g).

(c) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision 13e, paragraph (i).

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2024, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** (a) The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates.

(b) The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. The contracts must require that the managed care plans enter into contracts with the state's selected pharmacy benefit manager vendor to administer the pharmacy benefit.

(c) This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Sec. 8. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision to read:

Subd. 6i. **Directed pharmacy dispensing payment.** (a) The commissioner shall provide a directed pharmacy dispensing payment of $4.50 per filled prescription to eligible outpatient retail pharmacies in Minnesota to improve and maintain access to pharmaceutical services in rural and underserved areas of Minnesota. Managed care and county-based purchasing plans delivering services under section 256B.69 or 256B.692, and any pharmacy benefit managers under contract with these entities, must pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies for drugs dispensed to medical assistance enrollees. The directed pharmacy dispensing payment is in addition to, and must not supplant or reduce, any other dispensing fee paid by these entities to the pharmacy. Entities paying the directed pharmacy dispensing payment must not reduce other payments to the pharmacy as a result of payment of the directed pharmacy dispensing payment.

(b) For purposes of this subdivision, "eligible outpatient retail pharmacy" means an outpatient retail pharmacy licensed under chapter 151 that is not owned, either directly or indirectly or through an affiliate or subsidiary, by a pharmacy benefit manager licensed under chapter 62W or a health carrier, as defined in section 62A.011, subdivision 2, and that:

(1) is located in a medically underserved area or primarily serves a medically underserved population, as defined by the United States Department of Health and Human Services Health Resources and Services Administration under United States Code, title 42, section 254; or

(2) shares common ownership with 12 or fewer Minnesota pharmacies.

(c) In order to receive the directed pharmacy dispensing payment, a pharmacy must submit to the commissioner a form, developed by the commissioner, attesting that the pharmacy meets the requirements of paragraph (b).

(d) Managed care and county-based purchasing plans, and any pharmacy benefit managers under contract with these entities, shall pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies. The commissioner shall monitor the effect of this requirement on access to pharmaceutical services in rural and underserved areas of Minnesota. If, for any contract year, federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect removal of this subdivision. Contracts between managed care plans and county-based purchasing plans, and any pharmacy

benefit managers under contract with these entities, and providers to whom this subdivision applies, must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision. This subdivision expires if federal approval is not received for this subdivision at any time.

(e) This subdivision expires on December 31, 2026.

EFFECTIVE DATE. This section is effective July 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. **[256B.696] PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.**

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

(b) "Managed care plans" means health plans and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(c) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager selected pursuant to the procurement process in subdivision 2.

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a single pharmacy benefit manager to comply with the requirements set forth in subdivision 3. The single pharmacy benefit manager selected under this subdivision must be a prepaid ambulatory health plan, as defined in Code of Federal Regulations, title 42, section 438.2.

(b) When selecting the single pharmacy benefit manager, the commissioner must:

(1) accept applications for entities seeking to become the single pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the single pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) The contract required under paragraph (b), clause (3), must include provisions that prohibit the single pharmacy benefit manager from:

(1) requiring, enticing, or coercing an enrollee to obtain pharmacy services, including a prescription drug, from a pharmacy owned or otherwise affiliated with the single pharmacy benefit manager;

(2) communicating to an enrollee, in any manner, that the enrollee is required to obtain pharmacy services or have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy owned or affiliated with the single pharmacy benefit manager if there are other nonaffiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network;

(3) requiring an enrollee to obtain pharmacy services, including a prescription drug, exclusively through a mail order pharmacy;

(4) directly or indirectly retroactively denying or reducing a claim or aggregate of claims for pharmacy services, including prescription drugs, after adjudication of the claim or aggregate of claims;

(5) paying or reimbursing a pharmacy or pharmacist for the ingredient drug product component of pharmacist services, including a prescription drug, less than the lesser of national average drug acquisition cost; the Minnesota actual acquisition cost (MNAAC) as defined in section 256B.0625, subdivision 13e, paragraph (i); or the maximum allowable cost as defined in section 62W.08 of that pharmacy service or prescription drug, or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost minus two percent at the time the drug is administered or dispensed, plus a professional dispensing fee equal to the amount of the dispensing fee if it were determined pursuant to section 256B.0625, subdivision 13e; and

(6) denying a pharmacy or pharmacist the right to participate as a contract provider under the health plan if the pharmacy or pharmacist agrees to provide pharmacy services, including but not limited to prescription drugs that meet the terms and requirements set forth by the health plan and agrees to the terms of reimbursement set forth by the health plan company.

(d) Applicants for the single pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the single pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy

benefit manager's relationship with or obligation to the Department of Human Services, a health plan company, or a county-based purchasing organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with:

(i) a health plan company administering medical assistance or MinnesotaCare benefits in Minnesota or an affiliate of the health plan company;

(ii) a county-based purchasing organization;

(iii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates;

(iv) a drug wholesaler or distributor and its affiliates;

(v) a third-party payer and its affiliates; or

(vi) a pharmacy and its affiliates;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Minnesota with which the pharmacy benefit manager shares common ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Minnesota; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

Subd. 3. **Drug coverage.** (a) The commissioner may require the state pharmacy benefit manager to modify utilization review limitations, requirements, and strategies imposed by managed care plans on prescription drug coverage.

(b) The state pharmacy benefit manager is responsible for processing all point of sale outpatient pharmacy claims under the managed care delivery system. Managed care plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The pharmacy benefit manager selected is the exclusive pharmacy benefit manager used by health plan companies and county-based purchasing organizations when providing coverage to enrollees. The

commissioner may require the managed care plans and state pharmacy benefit manager to directly exchange data and files for members enrolled with managed care plans.

(c) All payment arrangements between the Department of Human Services, managed care plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(d) The commissioner must administer and oversee this section to:

(1) ensure proper administration of prescription drug benefits for managed care enrollees; and

(2) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

Subd. 4. **Prescription drug disclosures.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment the pharmacy benefit manager receives for prescribed drugs, including drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other financial benefits or payments related to services provided for a managed care plan.

(b) Each managed care plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The prices must include any rebates the state pharmacy benefit manager received from the drug manufacturer;

(2) unredacted copies of contracts between the state pharmacy benefit manager and enrolled pharmacies;

(3) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(4) any changes to the information previously disclosed in accordance with subdivision 2, paragraph (d); and

(5) any other information required by the commissioner.

(d) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(e) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

Subd. 5. **Program authority.** (a) To accomplish the requirements of subdivision 3, paragraph (d), the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

Subd. 6. **Pharmacies.** The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

Subd. 7. **Federal approval.** The commissioner must seek any necessary federal approvals to implement this section.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later, except that subdivision 7 is effective the day following final enactment. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 6
HUMAN SERVICES HEALTH CARE FINANCE

Section 1. Minnesota Statutes 2024, section 62A.673, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, ~~2025~~ 2028, telehealth also includes audio-only communication between

a health care provider and a patient ~~in accordance with subdivision 6, paragraph (b)~~ if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication or if, for substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication, the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

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

Sec. 2. Minnesota Statutes 2024, section 62M.17, subdivision 2, is amended to read:

Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan year, or a calendar year for fee-for-service providers under chapters 256B and 256L, a utilization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year, or the next calendar year for fee-for-service providers under chapters 256B and 256L, for any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(b) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a drug or device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

(c) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service

when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to patient harm. This paragraph expires December 31, 2025, for health benefit plans offered, sold, issued, or renewed on or after that date.

(d) Effective January 1, 2026, and applicable to health benefit plans offered, sold, issued, or renewed on or after that date, paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

(e) Paragraph (a) does not apply if a utilization review organization removes a brand name drug from its formulary or places a brand name drug in a benefit category that increases the enrollee's cost, provided the utilization review organization (1) adds to its formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

Sec. 3. Minnesota Statutes 2024, section 256.9657, is amended by adding a subdivision to read:

Subd. 2b. **Hospital assessment.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "eligible hospital" means a hospital licensed under section 144.50 and located in Minnesota;

(2) "net outpatient revenue" means the value reflecting total outpatient revenue less Medicare revenue as calculated from Worksheet G of the hospital's most recent Medicare cost report filed and showing in the Healthcare Cost Report Information System (HCRIS) as of August 1 of each year; and

(3) "total patient days" means the value reflecting total hospital inpatient days as reported on Worksheet S-3 of the hospital's most recent Medicare cost report filed and showing in HCRIS as of August 1 of each year.

(b) Subject to paragraphs (k) to (n), each eligible hospital must pay to the hospital directed payment program account assessments in an aggregate annual amount equal to the sum of the following:

(1) $120.22 multiplied by total patient days; and

(2) 5.96 percent of the hospital's net outpatient revenue.

(c) The assessment amount for calendar years 2026 and 2027 must be based on the total patient days and net outpatient revenue in 2021 for each eligible hospital.

(d) The commissioner may, after consultation with the Minnesota Hospital Association, modify the rates of assessment in paragraph (b) as necessary to comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or to otherwise maximize under this section federal financial participation for medical assistance. Notwithstanding the foregoing authorization to maximize federal financial participation for medical assistance, the commissioner must reduce the rates of assessment in paragraph (b) as necessary to ensure:

(1) the state's aggregated health care-related taxes on inpatient hospital services do not exceed five percent of the net patient revenue attributable to those services; and

(2) the state's aggregated health care-related taxes on outpatient hospital services do not exceed five percent of the net patient revenue attributable to those services.

(e) Eligible hospitals must pay the annual assessment amount under paragraph (b) to the commissioner by paying four equal quarterly assessments. Eligible hospitals must pay the quarterly assessments by January 1, April 1, July 1, and October 1 each year. Eligible hospitals must pay the assessments in the form and manner specified by the commissioner. An eligible hospital is prohibited from paying a quarterly assessment until the eligible hospital has received the applicable invoice under paragraph (f). The commissioner may make the assessment retroactive to the first quarter for which federal approval is effective.

(f) The commissioner must provide eligible hospitals with an invoice by December 1 for the assessment due January 1, March 1 for the assessment due April 1, June 1 for the assessment due July 1, and September 1 for the assessment due October 1 each year.

(g) The commissioner must notify each eligible hospital of its estimated annual assessment amount for the subsequent calendar year by October 15 each year.

(h) If any of the dates for assessments or invoices in paragraphs (e) to (g) fall on a holiday, the applicable date is the next business day.

(i) A hospital is not required to pay an assessment under this subdivision until the start of the first full fiscal year the hospital is an eligible hospital. A hospital that has merged with another hospital must have the hospital's assessment revised at the start of the first full

fiscal year after the merger is complete. A closed hospital is retroactively responsible for assessments owed for services provided through the final date of operations.

(j) If the commissioner determines that a hospital has underpaid or overpaid an assessment, the commissioner must notify the hospital of the unpaid assessment or of any refund due.

(k) Revenue from an assessment under this subdivision must only be used by the commissioner to pay the nonfederal share of the directed payment program under section 256B.1974.

(l) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when:

(1) federal financial participation is unavailable, disallowed, or reduced by at least 15 percent relative to the state's share of medical assistance as of April 1, 2025; or

(2) a directed payment under section 256B.1974 is not approved by the Centers for Medicare and Medicaid Services.

(m) The commissioner must make the following discounts from the inpatient portion of the assessment under paragraph (b), clause (1), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) for Hennepin Healthcare, a discount of 25 percent off the inpatient portion of the assessment rate;

(2) for Mayo Rochester, a discount of ten percent off the inpatient portion of the assessment rate; and

(3) for Gillette Children's Hospital, a discount of 90 percent off the inpatient portion of the assessment rate.

(n) The commissioner must make the following discounts from the outpatient portion of the assessment under paragraph (b), clause (2), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) for each critical access hospital or independent hospital located outside a city of the first class and paid under the Medicare prospective payment system, a discount of 40 percent off the outpatient portion of the assessment rate;

(2) for Gillette Children's Hospital, a discount of 90 percent off the outpatient portion of the assessment rate;

(3) for Hennepin Healthcare, a discount of 60 percent off the outpatient portion of the assessment rate; and

(4) for Mayo Rochester, a discount of 20 percent off the outpatient portion of the assessment rate.

(o) The commissioner must fully exempt the following from the assessment in this section:

(1) federal Indian Health Service facilities;

(2) state-owned or state-operated regional treatment centers and all state-operated services;

(3) federal Veterans Administration Medical Centers; and

(4) long-term acute care hospitals.

(p) If the federal share of the hospital directed payment program under section 256B.1974 is increased as the result of an increase to the federal medical assistance percentage, then the commissioner must reduce the assessment on a uniform percentage basis across eligible hospitals on which the assessment is imposed, such that the aggregate amount collected from hospitals under this subdivision does not exceed the total amount needed to maintain the same aggregate state and federal funding level for the directed payments authorized by section 256B.1974.

(q) Hospitals subject to the assessment under this subdivision must submit to the commissioner on an annual basis, in the form and manner specified by the commissioner in consultation with the Minnesota Hospital Association, all documentation necessary to determine the assessment amounts under this subdivision.

(r) Any disproportionate share hospital payments that are supplanted due to the implementation of the hospital directed payment program under section 256B.1974 must be redirected into the hospital directed payment program as an offset to the assessment under this section owed by all medical assistance disproportionate share hospitals as defined in section 256.969, subdivision 9, and reduce their assessments on a uniform basis.

(s) Any future state funding sources identified and used toward the hospital directed payment program under section 256B.1974 may be used to offset the assessment under this section.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 4. Minnesota Statutes 2024, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being

rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available, except that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the

next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;

(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and

(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.

(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

(k) Subject to subdivision 2g, effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include

a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692, subdivision 4, paragraph (a).

(l) Effective for discharges occurring on or after January 1, 2028, or on or after the date of federal approval, whichever is later, the commissioner must increase:

(1) payments for inpatient behavioral health services provided by hospitals paid under the DRG methodology by increasing the adjustment for behavioral health services under section 256.969, subdivision 2b, paragraph (e); and

(2) capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increase provided under this paragraph. Managed care and county-based purchasing plans must use the capitation rate increase provided under this clause to increase payment rates for inpatient behavioral health services provided by hospitals paid under the DRG methodology. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this clause, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this clause. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this clause. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

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

Sec. 5. Minnesota Statutes 2024, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a health care provider through telehealth in the same manner as if the service or consultation was delivered through in-person contact. Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide through telehealth;

(2) has written policies and procedures specific to services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the service is delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telehealth services; and

(5) has an established quality assurance process related to delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service delivered through telehealth to a medical assistance enrollee. Health care service records for services delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the health care provider's basis for determining that telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission used to deliver the service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's consultation with another physician through telehealth, the written opinion from the consulting physician providing the telehealth consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) Telehealth visits provided through audio and visual communication or accessible video-based platforms may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations using real-time two-way interactive audio and visual communication or accessible telehealth video-based

platforms to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes: the application of secure video conferencing consisting of a real-time, full-motion synchronized video; store-and-forward technology; and synchronous interactions, between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, email, or facsimile transmission or as specified by law, except that from July 1, 2025, to July 1, 2028, telehealth includes communication between a health care provider and a patient that solely consists of audio-only communication;

(2) "health care provider" means a health care provider as defined under section 62A.673; a community paramedic as defined under section 144E.001, subdivision 5f; a community health worker who meets the criteria under subdivision 49, paragraph (a); a mental health certified peer specialist under section 245I.04, subdivision 10; a mental health certified family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation worker under section 245I.04, subdivision 14; a mental health behavioral aide under section 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2024, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for

ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

(c) Effective for services provided statewide on or after January 1, 2026, medical assistance payment rates for ambulance services are increased by 15 percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase.

(d) Effective for services provided on or after January 1, 2026, medical assistance payment rates for ambulance services identified in this paragraph are increased by ten percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations, as defined in section 144E.001, is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

~~(c)~~ (e) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (a) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

~~(d)~~ (f) Managed care plans and county-based purchasing plans must provide a fuel adjustment for ambulance services rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must

allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

Sec. 7. Minnesota Statutes 2024, section 256B.0625, subdivision 25c, is amended to read:

Subd. 25c. **Applicability of utilization review provisions.** (a) Effective January 1, 2026, the following provisions of chapter 62M apply to the commissioner when delivering services under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2~~; and 62M.18~~.

(b) By April 1, 2026, and each April 1 thereafter, managed care plans and county-based purchasing plans when the plan is providing coverage to enrollees under chapter 256B or 256L, and the commissioner when delivering services under chapters 256B and 256L, must post on the entity's public website the following data for the immediately preceding calendar year for each health plan or program:

(1) the number of prior authorization requests for which an authorization was issued;

(2) the number of prior authorization requests for which an adverse determination was issued and sorted by:

(i) health care service;

(ii) whether the adverse determination was appealed; and

(iii) whether the adverse determination was upheld or reversed on appeal;

(3) the number of prior authorization requests that were submitted electronically and not by facsimile or email or other method pursuant to section 62J.497; and

(4) the reasons for prior authorization denial, including but not limited to:

(i) the patient did not meet prior authorization criteria;

(ii) the provider submitted incomplete information to the utilization review organization;

(iii) a change in treatment program; and

(iv) the patient is no longer covered by the plan or program.

(c) All information posted under paragraph (b) must be written in easily understandable language.

Sec. 8. Minnesota Statutes 2024, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent

or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner, when establishing organization encounter rates under this section for FQHCs and rural health clinics resulting from a merger of existing clinics or the acquisition of an existing clinic by another existing clinic, must use the combined costs and caseloads from the clinics participating in the merger or acquisition to set the encounter rate for the new clinic organization resulting from the merger or acquisition. The scope of services for the newly formed clinic must be inclusive of the scope of services of the clinics participating in the merger or acquisition;

~~(13)~~ (14) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

~~(14)~~ (15) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

(n) FQHC reimbursement for mental health targeted case management services is limited to:

(1) only those services described under section 256B.0625, subdivision 20, and provided in accordance with contracts executed with counties authorized to subcontract for mental health targeted case management services; and

(2) an FQHC's actual incurred costs as separately reported on the cost report submitted to the Centers for Medicare and Medicaid Services and further identified in reports submitted to the commissioner.

(o) Counties contracting with FQHCs for mental health targeted case management remain responsible for the nonfederal share of the cost of the provided mental health targeted case management services. The commissioner must bill each county for the nonfederal share of the mental health targeted case management costs as reported by the FQHC.

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

Sec. 9. Minnesota Statutes 2024, section 256B.0625, subdivision 54, is amended to read:

Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers services provided in a licensed birth center by a licensed health professional if the service would otherwise be covered if provided in a hospital.

(b) Facility services provided by a birth center shall be paid at ~~the lower of billed charges or 70~~ 100 percent of the ~~statewide average for a facility payment rate made to a hospital~~ hospital facility fee cost trended to current for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available. If a recipient is transported from a birth center to a hospital prior to the delivery, the payment for facility services to the birth center shall be ~~the lower of billed charges or 15~~ 100 percent of the ~~average~~ hospital facility ~~payment made to a hospital for the services provided~~ fee cost trended to current for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.

(c) ~~Nursery care~~ Facility services provided to a newborn by a birth center shall be paid ~~the lower of billed charges or 70~~ at 100 percent of ~~the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent calendar year for which complete claims data is available~~ the hospital facility fee for a normal newborn as determined using the most recent calendar year for which complete claims data is available, cost trended to current.

(d) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may not bill for any delivery services. Services are not covered if provided by an unlicensed traditional midwife.

(e) Licensed health professionals working in licensed birth centers shall be reimbursed for the full range of maternity care and newborn care services within their scope of practice, regardless of place of service. The commissioner shall review current birth center reimbursement and, in consultation with birth centers currently licensed in the state, develop revisions to current payment practices in order to ensure reimbursement for the full range of maternity care and newborn care services, including but not limited to:

(1) professional services for intrapartum care when a recipient is transferred from a birth center to a hospital prior to delivery;

(2) professional services billed with a home place of service code by a licensed health professional within their scope of practice;

(3) professional services when a licensed health professional provides any Minnesota mandated newborn screening, including but not limited to the newborn metabolic screen, CCHD screening, hearing screen, or any other medically necessary newborn screening, test, or assessment; and

(4) telehealth services provided by any licensed health professional working in a birth center.

(f) Managed care organizations and county-based purchasing plans contracted to provide medical assistance coverage under section 256B.69 shall reimburse licensed birth centers and licensed health professionals working in licensed birth centers for the full range of maternity care services within their scope of practice, regardless of place of service, as determined in paragraph (e) at no less than the medical assistance fee for service fee schedule for the year in which the service is provided.

~~(e)~~ (g) The commissioner shall apply for any necessary waivers from the Centers for Medicare and Medicaid Services to allow birth centers and birth center providers to be reimbursed.

Sec. 10. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 54a. **Home birth.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "birth services" means prenatal, labor, birth, and postpartum services;

(2) "eligible provider" means a licensed or certified health care professional eligible for reimbursement under the medical assistance program; and

(3) "low-risk patient for birth services" means a person undergoing a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care who anticipates a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

(b) Medical assistance covers birth services provided at home when the following conditions are met:

(1) the birth services are provided by an eligible provider whose scope of practice and experience includes home birth;

(2) the recipient is a low-risk patient for birth services; and

(3) the recipient has a plan of care that includes:

(i) a consent form detailing the risks and benefits of home birth signed by the recipient;

(ii) sufficient visits, test results, and follow-up consultations as needed to establish that the recipient is a low-risk patient for birth services; and

(iii) a plan for transfer to a hospital as needed.

(c) Services provided under this subdivision by an eligible provider must be paid at a rate at least equal to 100 percent of the rate paid to a physician performing the same services. An eligible provider who does not perform the delivery must not bill for any delivery services.

(d) Supplies used for birth services under this subdivision must be paid at 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data are available. If a recipient is transported from a home to a hospital prior to the delivery, the payment for the supplies used for birth services under this subdivision must be the lower of billed charges or 15 percent of the statewide average for a facility payment rate made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data are available.

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

Sec. 11. Minnesota Statutes 2024, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments.** (a) The commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3 to each eligible individual under subdivision 2 that selects the health home as a provider. This paragraph expires on the date that paragraph (b) becomes effective.

(b) Effective January 1, 2028, or upon federal approval, whichever is later, the commissioner shall make payments to each designated provider for the provision of health

home services described in subdivision 3, except for behavioral health services, to each eligible individual under subdivision 2 who selects the health home as a provider.

Sec. 12. Minnesota Statutes 2024, section 256B.0757, is amended by adding a subdivision to read:

Subd. 5a. **Payments for behavioral health home services.** (a) Notwithstanding subdivision 5, the commissioner must implement a single statewide reimbursement rate for behavioral health home services under this section. The rate must be no less than $425 per member per month. The commissioner must adjust the reimbursement rate for behavioral health home services annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

(b) The commissioner must review and update the behavioral health home services rate under paragraph (a) at least every four years. The updated rate must account for the average hours required for behavioral health home team members spent providing services and the Department of Labor prevailing wage for required behavioral health home team members. The updated rate must ensure that behavioral health home services rates are sufficient to allow providers to meet required certifications, training, and practice transformation standards; staff qualification requirements; and service delivery standards.

(c) Managed care plans and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this subdivision. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

(d) This subdivision is effective January 1, 2028, or upon federal approval, whichever is later.

Sec. 13. Minnesota Statutes 2024, section 256B.1973, is amended by adding a subdivision to read:

Subd. 9. **Interaction with other directed payments.** An eligible provider under subdivision 3 may participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program. A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of its intention to participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. The election under this subdivision is a onetime election, except that if an eligible provider elects to participate in the hospital directed payment program, and the hospital directed payment program expires, then the eligible provider may thereafter elect to participate in the directed payment program under this section.

EFFECTIVE DATE. (a) This section is effective on the later of January 1, 2026, or federal approval of all of the following:

(1) this section;

(2) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b; and

(3) the amendments in this act to Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 14. **[256B.1974] HOSPITAL DIRECTED PAYMENT PROGRAM.**

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

(b) "Health plan" means a managed care plan or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(c) "Hospital" means a hospital licensed under section 144.50.

Subd. 2. **Required conditions for program.** The hospital directed payment program is contingent on the satisfaction of all requirements necessary for the collection of an assessment

under section 256.9657, and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment program that is a state-directed fee schedule requirement that includes a quarterly payment amount to be submitted by each health plan to each hospital, the commissioner must determine the quarterly payment amount using the average commercial payer rate, or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved. The commissioner must ensure that the application of the quarterly payment amounts maximizes the amount generated by the hospital assessment in section 256.9657, subdivision 2b, for allowable directed payments and does not result in payments exceeding federal limits.

(b) The commissioner must use an annual settle-up process that occurs within the time period allowed for medical assistance managed care claims adjustments.

(c) On and after January 1, 2028, if the federal regulations set forth in Code of Federal Regulations, title 42, parts 430, 438, and 457, remain effective, the hospital directed payment program must be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(d) For each federally approved directed payment program that is a state-directed fee schedule requirement, the commissioner must develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that hospitals receive the entire permissible value of the federally approved directed payment. If federal approval of a directed payment under this subdivision is retroactive, the commissioner must make a onetime pro rata increase to the quarterly payment amount and the initial payments to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

(e) Directed payments under this section must only be used to supplement, and not supplant, medical assistance reimbursement to hospitals. The directed payment program must not modify, reduce, or offset the medical assistance payment rates determined for each hospital as required by section 256.969.

(f) The commissioner must require health plans to make quarterly directed payments according to this section.

(g) Health plans must make quarterly directed payments using electronic funds transfers, if the hospital provides the information necessary to process such transfers, and in accordance

with directions provided by the commissioner. Health plans must make quarterly directed payments:

(1) for the first two quarters for which such payments are due, within 30 calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section; and

(2) for all subsequent quarters, within ten calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section.

(h) The commissioner must publish on the Department of Human Services' website, on a quarterly basis, the dates that the health plans completed their required quarterly payments under this section.

(i) Payments to health plans that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this section must not be reduced as a result of this section.

(j) The commissioner must publish all directed payments owed to each hospital from each health plan on the department's website for at least two years. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

(k) By December 1 each year, the commissioner must notify each hospital of any changes to the payment methodologies in this section, including but not limited to changes in the directed payment rates, the aggregate directed payment amount for all hospitals, and the hospital's directed payment amount for the upcoming calendar year.

(l) The commissioner must distribute payments required under this section for each hospital within 30 days of a quarterly assessment under section 256.9657, subdivision 2b, being received. The commissioner must pay the directed payments to health plans under contract no later than January 1, April 1, July 1, and October 1 each year.

(m) A hospital is not entitled to payments under this section until the start of the first full fiscal year it is an eligible hospital. A hospital that has merged with another hospital must have its payments under this section revised at the start of the first full fiscal year after the merger is complete. A closed hospital is entitled to the payments under this section for services provided through the final date of operations.

Subd. 4. **Health plan duties; submission of claims.** Each health plan must submit to the commissioner, in accordance with its contract with the commissioner to serve as a

managed care organization in medical assistance, payment information for each claim paid to a hospital for services provided to a medical assistance enrollee. Health plans must allow each hospital to review the health plan's own paid claims detail to enable proper validation that the medical assistance managed care claims volume and content is consistent with the hospital's internal records. To support the validation process for the directed payment program, health plans must permit the commissioner to share inpatient and outpatient claims-level details with hospitals identifying only those claims where the prepaid medical assistance program under section 256B.69 is the payer source. Hospitals must provide notice of discrepancies in claims paid to the commissioner in a form determined by the commissioner. The commissioner is authorized to determine the final disposition of the validation process for disputed claims.

Subd. 5. **Health plan duties; directed payment add-on.** (a) Each health plan must make, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, a directed payment to each hospital. The amount of the directed payment to the hospital must be equal to the payment amounts the plan received from the commissioner for the hospital.

(b) Health plans are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a hospital in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section;

(2) unnecessarily delaying a directed payment to a hospital; or

(3) recouping or offsetting a directed payment for any reason, except as expressly authorized by the commissioner.

Subd. 6. **Hospital duties; quarterly supplemental directed payment add-on.** (a) A hospital receiving a directed payment under this section is prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a managed care organization in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section; or

(2) directly passing on the cost of an assessment to patients or nonmedical assistance payers, including as a fee or rate increase.

(b) A hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the rate year. This subdivision does not prohibit a hospital from negotiating with a payer for a rate increase.

(c) Any hospital receiving a directed payment under this section must meet the commissioner's standards for directed payments as described in subdivision 7.

Subd. 7. **State minimum policy goals established.** (a) The effect of the directed payments under this section must align with the state's policy goals for medical assistance enrollees. The directed payments must be used to maintain quality and access to a full range of health care delivery mechanisms for medical assistance enrollees, and specifically provide improvement for one of the following quality measures:

(1) overall well child visit rates;

(2) maternal depression screening rates; or

(3) colon cancer screening rates.

(b) The commissioner, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services quality measures performance evaluation criteria and a methodology to regularly measure access to care and the achievement of state policy goals described in this subdivision.

(c) The quality measures evaluation data, as determined by paragraph (b), must be reported to the Centers for Medicare and Medicaid Services after at least 12 months of directed payments to hospitals.

Subd. 8. **Administrative review.** Before making the payments required under this section, and on at least an annual basis, the commissioner must consult with and provide for review of the payment amounts by a permanent select committee established by the Minnesota Hospital Association. Any data or information reviewed by members of the committee are data not on individuals, as defined in section 13.02. The committee's members must not include any current employee or paid consultant of any hospital.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval for all of the following:

(1) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to this section.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 15. **[256B.1975] HOSPITAL DIRECTED PAYMENT PROGRAM ACCOUNT.**

Subdivision 1. **Account established; appropriation.** (a) The hospital directed payment program account is created in the special revenue fund in the state treasury.

(b) Money in the account, including interest earned, is annually appropriated to the commissioner for the purposes specified in section 256B.1974.

(c) Transfers from this account to another fund are prohibited, except as necessary to make the payments required under section 256B.1974.

Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that details the activities and uses of money in the hospital directed payment program account, including the metrics and outcomes of the policy goals established by section 256B.1974, subdivision 7.

EFFECTIVE DATE. This section is effective on the later of January 1, 2026, or federal approval of the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 16. Minnesota Statutes 2024, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. ~~**Physician and professional services**~~ **Reimbursement adjustments.** ~~(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:~~

~~(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;~~

~~(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and~~

~~(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases~~

~~except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.~~

~~(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.~~

~~(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice registered nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.~~

~~(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.~~

~~(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.~~

~~(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech~~

~~pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.~~

~~(g)~~ (a) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(h)~~ (b) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

~~(i)~~ (c) The commissioner may reimburse physicians and other licensed professionals for costs incurred to pay the fee for testing newborns who are medical assistance enrollees for heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when the sample is collected outside of an inpatient hospital or freestanding birth center and the cost is not recognized by another payment source.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval of the amendments in this act to Minnesota Statutes, sections 256B.76, subdivision 6, and 256B.768, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2024, section 256B.76, subdivision 6, is amended to read:

Subd. 6. **Medicare relative value units.** (a) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor. This paragraph expires on the date that paragraph (b) becomes effective.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after January 1, 2007, the commissioner must make payments for physician and professional services based on the Medicare relative value units (RVUs).

~~(b)~~ (c) Effective for services rendered on or after January 1, 2025, rates for mental health services reimbursed under the resource-based relative value scale (RBRVS) must be equal to 83 percent of the Medicare Physician Fee Schedule. This paragraph expires on the date that section 256B.768 becomes effective.

~~(c)~~ (d) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires on the date that section 256B.768 becomes effective.

Sec. 18. Minnesota Statutes 2024, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

Subdivision 1. **Rates effective 2026.** ~~(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.~~

~~(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.~~

~~(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services~~

~~under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256K.10. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.~~

~~(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.~~

~~(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be increased by three percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18; early intensive developmental behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.~~

~~(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing~~

~~plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.~~

(a) Effective for services rendered on or after January 1, 2026, the commissioner must establish market-based payment rates for the following services:

(1) children's therapeutic services and supports under section 256B.0943;

(2) child and family psychoeducation services under section 256B.0671, subdivision 5;

(3) clinical care consultation services under section 256B.0671, subdivision 7; and

(4) mental health certified family peer specialist services under section 256B.0616.

(b) Rates established under paragraph (a) must not be lower than:

(1) the payment rates recommended in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, and published by the Department of Human Services on January 22, 2024; or

(2) the payment rates in effect on December 31, 2025.

Subd. 2. **Rates effective 2027.** (a) Effective for services rendered on or after January 1, 2027, the commissioner must establish market-based payment rates for the following services:

(1) adult day treatment services under section 256B.0671, subdivision 3;

(2) adult rehabilitative mental health services under section 256B.0623;

(3) adult mental health peer support specialist services under section 256B.0615;

(4) dialectical behavioral therapy under section 256B.0671, subdivision 6;

(5) explanation of findings under section 256B.0671, subdivision 4;

(6) mental health crisis response services under section 256B.0624;

(7) mental health provider travel time under section 256B.0625, subdivision 43;

(8) neuropsychological testing under section 256B.0671, subdivision 9;

(9) partial hospitalization services under section 256B.0671, subdivision 12; and

(10) psychotherapy services under section 256B.0671, subdivision 11, incorporating biofeedback.

(b) Rates established under paragraph (a) must not be lower than:

(1) the payments rates recommended in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, and published by the Department of Human Services on January 22, 2024; or

(2) the payment rates in effect on December 31, 2026.

Subd. 3. **Capitation payments.** The commissioner must adjust capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rates provided in this section. Managed care and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this section. The commissioner must monitor the effect of this rate adjustment on enrollee access to behavioral health services. If for any contract year federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision.

Subd. 4. **Inflation adjustment.** The commissioner must adjust the reimbursement rate for services under this section annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

Subd. 5. **Exceptions.** (a) This section does not apply to federally qualified health centers, rural health centers, Indian health services, or certified community behavioral health clinics or to cost-based rates or rates that are negotiated with the county.

(b) This section does not apply to services with reimbursement rates established pursuant to section 256B.768.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval of this section and Minnesota Statutes, section 256B.768, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2024, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** ~~(a)~~ Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation.

Subd. 2. **Classification of therapies as basic care services.** ~~Effective July 1, 2010,~~ The commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in ~~this paragraph~~ subdivision 1 shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~ Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1 effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

Subd. 4. **Temporary payment reductions effective September 1, 2011.** ~~(c)~~ (a) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

~~(d)~~ (b) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

Subd. 5. **Payment increases effective September 1, 2014.** ~~(e)~~ (a) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent.

(b) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this ~~paragraph~~ subdivision.

Subd. 6. **Temporary payment reductions effective July 1, 2014.** ~~(f)~~ Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent.

Subd. 7. **Payment increases effective July 1, 2015.** (a) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under ~~paragraphs (i) and (j)~~ subdivisions 9 and 10.

~~(g)~~ (b) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under ~~this~~ paragraph (b).

Subd. 8. **Exempt services.** ~~(h)~~ This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

Subd. 9. **Individually priced items.** ~~(i)~~ (a) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service.

(b) This ~~paragraph~~ subdivision does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic

testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item.

(c) The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

Subd. 10. **Rate increases effective July 1, 2015.** ~~(j)~~ (a) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

~~This~~ (b) Paragraph (a) does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in ~~paragraph (i)~~ subdivision 9.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this ~~paragraph~~ subdivision.

Subd. 11. **Rates for ventilators.** ~~(k)~~ (a) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate.

(b) Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

(c) For payments made in accordance with this ~~paragraph~~ subdivision, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this ~~paragraph~~ subdivision.

Subd. 12. **Rates subject to the upper payment limit.** ~~(l)~~ Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this ~~paragraph~~ subdivision.

Subd. 13. **Temporary rates for enteral nutrition and supplies.** ~~(m)~~ (a) For dates of service on or after July 1, 2023, through June 30, 2025, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate must be the payment rate in effect on June 30, 2023.

(b) This subdivision expires June 30, 2025.

Subd. 14. **Rates for enteral nutrition and supplies.** ~~(n)~~ For dates of service on or after July 1, 2025, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision and updated annually each January 1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner for the previous calendar year, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment must be the manufacturer's suggested retail price of that product or supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment must be the actual acquisition cost of that product or supply plus 20 percent.

Subd. 15. **Rates for phototherapy services.** For dates of service on or after July 1, 2025, the payment rate for phototherapy services provided in the home setting must include a service fee in the amount of $520 per patient episode, in addition to the daily rental rate for the medical equipment in subdivision 12. The commissioner shall provide an annual inflation adjustment for the phototherapy service fee. The index for the inflation adjustment must be based on the Consumer Price Index for All Urban Consumers increase published by the Bureau of Labor Statistics.

Sec. 20. **[256B.768] MEDICARE RATE ALIGNMENT.**

Subdivision 1. **Medicare physician fee schedule rates.** (a) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, the commissioner must make payments based on the resource-based relative value scale for all services:

(1) covered in medical assistance; and

(2) with a corresponding rate and procedure code in the Medicare Physician Fee Schedule.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, rates must be at least equal to 100 percent of the Medicare Physician Fee Schedule if the service:

(1) is reimbursed in medical assistance under the resource-based relative value scale; and

(2) has a corresponding rate and procedural code in the Medicare Physician Fee Schedule.

(c) For services rendered on or after January 1, 2026, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care plans and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this subdivision. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted

in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

Subd. 2. **Applicable fee schedule.** For purposes of this section, the applicable Medicare Physician Fee Schedule is the most recent Medicare Physician Fee Schedule Final Rule issued by the Centers for Medicare and Medicaid Services in effect at the time the service was rendered.

Subd. 3. **Exceptions.** This section does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county.

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

Sec. 21. Minnesota Statutes 2024, section 295.52, subdivision 1, is amended to read:

Subdivision 1. **Hospital tax.** A tax is imposed on each hospital equal to ~~1.8~~ two percent of its gross revenues.

Sec. 22. Minnesota Statutes 2024, section 295.52, subdivision 1a, is amended to read:

Subd. 1a. **Surgical center tax.** A tax is imposed on each surgical center equal to ~~1.8~~ two percent of its gross revenues.

Sec. 23. Minnesota Statutes 2024, section 295.52, subdivision 2, is amended to read:

Subd. 2. **Provider tax.** A tax is imposed on each health care provider equal to ~~1.8~~ two percent of its gross revenues.

Sec. 24. Minnesota Statutes 2024, section 295.52, subdivision 3, is amended to read:

Subd. 3. **Wholesale drug distributor tax.** A tax is imposed on each wholesale drug distributor equal to ~~1.8~~ two percent of its gross revenues.

Sec. 25. Minnesota Statutes 2024, section 295.52, subdivision 4, is amended to read:

Subd. 4. **Use tax; legend drugs.** (a) A person that receives legend drugs for resale or use in Minnesota, other than from a wholesale drug distributor that is subject to tax under subdivision 3, is subject to a tax equal to the price paid for the legend drugs multiplied by

~~1.8~~ two percent. Liability for the tax is incurred when legend drugs are received or delivered in Minnesota by the person.

(b) A tax imposed under this subdivision does not apply to purchases by an individual for personal consumption.

Sec. 26. **[295.525] MCO ASSESSMENT ON HEALTH PLAN COMPANIES.**

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

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

(c) "Enrollee" has the meaning given in section 62Q.01, except that enrollee does not include:

(1) an individual enrolled in a Medicare plan;

(2) a plan-to-plan enrollee; or

(3) an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, to the extent the imposition of the assessment under this section is preempted pursuant to United States Code, title 5, section 8909, subsection (f).

(d) "Health plan" has the meaning given in section 62Q.01.

(e) "Health plan company" has the meaning given in section 62Q.01.

(f) "Medical assistance" means the medical assistance program established under chapter 256B.

(g) "Medical assistance enrollee" means an enrollee in medical assistance or MinnesotaCare for whom the Department of Human Services directly pays the health plan company a capitated payment.

(h) "MinnesotaCare" means the MinnesotaCare program established under chapter 256L.

(i) "Plan-to-plan enrollee" means an individual who receives coverage for health care services through a health plan pursuant to a subcontract from another health plan.

Subd. 2. **MCO assessment.** (a) An annual assessment is imposed on health plan companies for each calendar year beginning in calendar year 2026. The total annual assessment amount is equal to the sum of the amounts assessed for medical assistance enrollees under paragraph (b) and for nonmedical assistance enrollees under paragraph (c).

(b) The amount assessed for medical assistance enrollees is equal to the sum of the following:

(1) for medical assistance enrollees 0 to 60,000, $0 per enrollee;

(2) for medical assistance enrollees 60,001 to 100,000, $340 per enrollee;

(3) for medical assistance enrollees 100,001 to 200,000, $365 per enrollee; and

(4) for medical assistance enrollees 200,001 to 350,000, $380 per enrollee.

(c) The amount assessed for nonmedical assistance enrollees is equal to the sum of the following:

(1) for nonmedical assistance enrollees 0 to 60,000, $0 per enrollee;

(2) for nonmedical assistance enrollees 60,001 to 100,000, 50 cents per enrollee;

(3) for nonmedical assistance enrollees 100,001 to 200,000, 75 cents per enrollee; and

(4) for nonmedical assistance enrollees 200,001 to 350,000, $1 per enrollee.

(d) The commissioner must annually use the commissioner's authority as necessary to modify the rate of assessment, provided under paragraph (e), such that the annual assessment imposed under this subdivision equals 2.8 percent of the health plan companies' aggregate gross revenue.

(e) The commissioner may, after consultation with health plan companies likely to be affected, modify the rate of assessment, as set forth in paragraphs (a) to (d), as necessary to:

(1) comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or to otherwise maximize under this section federal financial participation for medical assistance; and

(2) comply with paragraph (d).

(f) Unpaid assessment amounts accrue interest at a rate of ten percent per annum, beginning the day following the assessment payment's due date. A penalty, equal to the total accrued interest charge, is imposed monthly on payments 60 days or more overdue until the payment, penalty, and interest are paid in full.

Subd. 3. **Assessment computation; collection.** (a) The commissioner must annually determine the following for each health plan company:

(1) total enrollment for the calendar year;

(2) total Medicare enrollment for the calendar year;

(3) total medical assistance enrollment for the calendar year;

(4) total plan-to-plan enrollment for the calendar year;

(5) total enrollment through the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, for the calendar year; and

(6) total other enrollment for the calendar year that is not otherwise counted in clauses (2) to (5).

(b) Health plan companies must provide any information requested by the commissioner for the purpose of this subdivision, provided that the commissioner determines such information is necessary to accurately determine the information in paragraph (a).

(c) The commissioner may correct errors in data provided to the commissioner by a health plan company to the extent necessary to accurately determine the information in paragraph (a).

(d) For purposes of calculating the information in paragraph (a) for a health plan company, the commissioner must count any individual that was an enrollee of a health plan at any point of the calendar year, regardless of the enrollee's duration as an enrollee of the health plan.

(e) The commissioner must annually use the information in paragraph (a) to compute the assessment for each health plan company.

(f) The commissioner must collect the annual assessment for each health plan company in four equal installments, in the manner and on the schedule determined by the commissioner. The commissioner is prohibited from collecting any amount under this section until 20 days after the commissioner has notified the health plan company of:

(1) the effective date of this section;

(2) the assessment due dates for the applicable calendar year; and

(3) the annual assessment amount.

(g) The commissioner may waive all or part of the interest or penalty imposed on a health plan company under subdivision 2, paragraph (f), if the commissioner determines the interest or penalty is likely to create an undue financial hardship on the health plan company or a significant financial difficulty in providing necessary services to medical assistance enrollees. A waiver under this paragraph must be contingent on the health plan company's agreement to make assessment payments on an alternative schedule, determined

by the commissioner, that accounts for the health plan company's finances and the potential impact on the delivery of services to medical assistance enrollees.

(h) In the event of a merger, acquisition, or other transaction that results in the transfer of health plan responsibility to another health plan company or similar entity during calendar years 2026 to 2029, the surviving, acquiring, or controlling health plan company or similar entity shall be responsible for paying the full assessment amount as provided in this section that would have been the responsibility of the health plan company to which that full assessment amount was assessed upon the effective date of the transaction. If a transaction results in the transfer of health plan responsibility for only some of a health plan's enrollees under this section but not all enrollees, the full assessment amount as provided in this section remains the responsibility of that health plan company to which that full assessment amount was assessed.

Subd. 4. **MCO assessment expenditures.** (a) All amounts collected by the commissioner under this section must be deposited in the health care access fund.

(b) All amounts collected by the commissioner under this section are annually appropriated to the commissioner to provide nonfederal money for medical assistance and MinnesotaCare program rate changes made in this act related to:

(1) ambulance services under section 256B.0625, subdivision 17a;

(2) behavioral health home services under section 256B.0757;

(3) mental health services under section 256B.761;

(4) services reimbursed under the resource-based relative value scale and with a corresponding rate and procedural code in the Medicare Physician Fee Schedule under section 256B.768; and

(5) inpatient behavioral health services provided by hospitals paid under the DRG methodology.

(c) The assessment money must be used to supplement money for medical assistance from the general fund.

(d) The commissioner must provide an annual report to all health plan companies, in a time and manner determined by the commissioner. The report must identify the assessments imposed on each health plan company pursuant to this section, account for all money raised by the MCO assessment, and provide an itemized accounting of expenditures from the fund.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval for the assessment established in this section to be considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation, including but not limited to federal approval of a waiver under Code of Federal Regulations, title 42, section 433.72, if such waiver is necessary to receive health care-related taxes without a reduction in federal financial participation, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 27. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ENHANCED FEDERAL REIMBURSEMENT FOR FAMILY PLANNING SERVICES IN MEDICAL ASSISTANCE.**

The commissioner of human services must make the systems modification necessary to claim enhanced federal reimbursement for all family planning services under the medical assistance program.

Sec. 28. **IMPLEMENTATION OF HOSPITAL ASSESSMENT AND DIRECTED PAYMENT PROGRAM.**

(a) The commissioner of human services must immediately begin all necessary claims analysis to calculate the assessment and payments required under Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a request for federal approval to implement the hospital assessment described in Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program under Minnesota Statutes, section 256B.1974. At least 15 days before submitting the request for approval, the commissioner must make available to the public the draft assessment requirements, draft directed payment details, and an estimate of each assessment amount for each hospital without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k).

(c) During the design and prior to submission of the request for approval under paragraph (b), the commissioner of human services must consult with the Minnesota Hospital Association and any hospitals without an exemption from the assessment pursuant to

Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k), and that are not members of the Minnesota Hospital Association.

(d) If federal approval is received for the request under paragraph (b), the commissioner of human services must provide at least 15 days of public posting and review of the federally approved terms and conditions for the assessment and the directed payment program prior to any assessment under Minnesota Statutes, section 256.9657, subdivision 2b, becoming due from a hospital.

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

Sec. 29. **FEDERAL APPROVAL; WAIVERS.**

(a) The commissioner must request, as the commissioner determines necessary, federal approval for the MCO assessment on health plan companies established in this act to be considered a permissible health-care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation.

(b) To obtain the federal approval under paragraph (a), the commissioner may apply for a waiver of the federal broad-based requirement for health care-related taxes, uniform requirement for health-care-related taxes, and any other provision of federal law necessary to implement Minnesota Statutes, section 295.525.

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

Sec. 30. **BUDGET NEUTRALITY; RATE ADJUSTMENTS.**

(a) By October 1 of each year, the commissioner of human services must determine the difference between the actual costs or forecasted costs to the medical assistance and MinnesotaCare programs attributable to the program changes in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (5), and the revenue from the MCO assessment imposed under Minnesota Statutes, section 295.525, subdivision 2, including federal financial participation.

(b) For each fiscal year, the commissioner of human services must certify the difference between the actual costs or forecasted costs to the medical assistance and MinnesotaCare programs determined under paragraph (a), and report the difference in costs to the commissioner of management and budget at least four weeks prior to a forecast under Minnesota Statutes, section 16A.103.

(c) If for any fiscal year, the cumulative costs attributable to the program changes in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (5), exceed

revenue from the MCO assessment imposed under Minnesota Statutes, section 295.525, subdivision 2, as determined under paragraph (a), the commissioner of human services must reduce the costs to the medical assistance and MinnesotaCare programs attributable to the program changes in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (5). The commissioner's reduction under this paragraph must be on a uniform percentage basis across the rate increases provided in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (5).

Sec. 31. **TREND LIMIT; CALCULATION.**

(a) Beginning January 1, 2027, and ending June 30, 2029, the commissioner of human services may limit the trend increase in rates paid to managed care plans and county-based purchasing plans under Minnesota Statutes, sections 256B.69 and 256B.692, by an amount equal to the value of a 0.35 percent reduction in trend in medical assistance. Managed care rates must meet actuarial soundness and rate development requirements under Code of Federal Regulations, title 42, part 438, subpart A.

(b) In the November 2025 forecast, the commissioner of human services, in consultation with the commissioner of management and budget, must reduce the forecasted trend growth in managed care for medical assistance expenditures in fiscal years 2027, 2028, and 2029. The reduction must not be less than $7,784,000 in fiscal year 2027, $8,219,000 in fiscal year 2028, and $8,446,000 in fiscal year 2029.

Sec. 32. **APPROPRIATION.**

$10,000,000 is appropriated in fiscal year 2027 from the health care access fund to the commissioner of human services for increases to payments for inpatient behavioral health services provided by hospitals paid under the DRG methodology under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (l).

Sec. 33. **REPEALER.**

Minnesota Statutes 2024, section 256B.0625, subdivision 38, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval of this section and the amendments in this act to Minnesota Statutes, sections 256B.76, subdivision 6, and 256B.761, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 7

HUMAN SERVICES HEALTH CARE POLICY

Section 1. Minnesota Statutes 2024, section 62Q.522, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(c) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy~~, excluding vasectomies~~. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

(d) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

(e) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent: (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration; and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2024, section 256B.0371, subdivision 3, is amended to read:

Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care and county-based purchasing plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care and county-based purchasing plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, ~~2026~~ 2030, for all recipients of medical assistance and MinnesotaCare, including persons served under fee-for-service and persons receiving services through managed care and county-based purchasing plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation; and

(10) management of third-party liability requirements.

~~(c) Dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.~~

~~(d)~~ (c) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care and county-based purchasing plans for dental services under section 62K.14.

~~(e)~~ (d) The contract with the dental administrator must include a provision that states that if the dental administrator fails to meet, by calendar year ~~2029~~ 2032, a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare received at least one dental visit during the calendar year, the contract must be terminated and the commissioner must enter into a contract with a new dental administrator as soon as practicable.

~~(f)~~ (e) The commissioner shall implement this subdivision in consultation with representatives of providers who provide dental services to patients enrolled in medical assistance or MinnesotaCare, including but not limited to providers serving primarily low-income and socioeconomically complex populations, and with representatives of managed care plans and county-based purchasing plans.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 77. **Vasectomies.** (a) Medical assistance covers vasectomies.

(b) Medical assistance must meet the requirements with respect to coverage of vasectomies that would otherwise apply to a health plan under section 62Q.522, except that medical assistance is not required to comply with any provision of section 62Q.522 if compliance with the provision would:

(1) prevent the state from receiving federal financial participation for the coverage under this subdivision;

(2) result in a lower level of coverage or reduced access to coverage for medical assistance enrollees; or

(3) violate Code of Federal Regulations, title 42, part 441, subpart F.

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

Sec. 4. Minnesota Statutes 2024, section 256B.76, is amended by adding a subdivision to read:

Subd. 1a. **Certain long-term ambulatory electrocardiogram monitoring services.** (a) For the purpose of this subdivision, "long-term ambulatory electrocardiogram monitoring services" means the provision of external cardiac patch monitoring devices to patients to

wear for 48 hours or greater and the interpretation of data gathered by such devices to detect heart arrhythmias that can lead to stroke, cardiac arrest, or other comorbidities or medical complications if not correctly diagnosed.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner must reimburse diagnostic testing facilities providing long-term ambulatory electrocardiogram monitoring services at 100 percent of the Medicare Physician Fee Schedule rate for such services or higher.

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

ARTICLE 8
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2024, section 245.4661, subdivision 2, is amended to read:

Subd. 2. **Program design and implementation.** Adult mental health initiatives shall be responsible for designing, planning, improving, and maintaining a mental health service delivery system for adults with serious and persistent mental illness that would:

(1) provide an expanded array of services from which clients can choose services appropriate to their needs;

(2) be based on purchasing strategies that improve access and coordinate services without cost shifting;

(3) prioritize evidence-based services and implement services that are promising practices or theory-based practices so that the service can be evaluated according to subdivision 5a;

(4) incorporate existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors; and

(5) utilize ~~existing categorical funding streams and reimbursement sources in combined and creative ways, except~~ adult mental health initiative funding only after all other eligible funding sources have been applied. Appropriations and all funds that are attributable to the operation of state-operated services under the control of the Direct Care and Treatment executive board are excluded unless appropriated specifically by the legislature for a purpose consistent with this section.

Sec. 2. Minnesota Statutes 2024, section 245.4661, subdivision 6, is amended to read:

Subd. 6. **Duties of commissioner.** (a) For purposes of adult mental health initiatives, the commissioner shall facilitate integration of funds or other resources as needed and requested by each adult mental health initiative. These resources may include:

(1) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(2) other mental health special project funds;

(3) medical assistance, MinnesotaCare, and housing support under chapter 256I if requested by the adult mental health initiative's managing entity and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(4) regional treatment center resources, with consent from the Direct Care and Treatment executive board.

~~(b) The commissioner shall consider the following criteria in awarding grants for adult mental health initiatives:~~

~~(1) the ability of the initiatives to accomplish the objectives described in subdivision 2;~~

~~(2) the size of the target population to be served; and~~

~~(3) geographical distribution.~~

~~(c)~~ (b) The commissioner shall review overall status of the initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

~~(d)~~ (c) The commissioner may waive administrative rule requirements that are incompatible with the implementation of the adult mental health initiative.

~~(e)~~ (d) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules that are incompatible with the implementation of the adult mental health initiative.

~~(f)~~ (e) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the adult mental health initiative.

Sec. 3. Minnesota Statutes 2024, section 245.4661, subdivision 7, is amended to read:

Subd. 7. **Duties of adult mental health initiative board.** The adult mental health initiative board, or other entity which is approved to administer an adult mental health initiative, shall:

(1) administer the initiative in a manner that is consistent with the objectives described in subdivision 2 and the planning process described in subdivision 5;

(2) assure that no one is denied services that they would otherwise be eligible for; and

(3) provide the commissioner of human services with timely and pertinent information through the ~~following methods:~~

~~(i) submission of mental health plans and plan amendments which are based on a format and timetable determined by the commissioner;~~

~~(ii) submission of social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the initiative's managing entity and the commissioner; and~~

~~(iii)~~ submission of data and participation in an evaluation of the adult mental health initiatives, to be designed cooperatively by the commissioner and the initiatives. For services provided to American Indians in Tribal Nations or urban Indian communities, oral reports using a system designed in partnership between the commissioner and the reporting community satisfy the requirements of this clause.

Sec. 4. Minnesota Statutes 2024, section 245.4871, subdivision 5, is amended to read:

Subd. 5. **Child.** "Child" means a person under 18 years of age, or a person 18 years of age or older and under 21 years of age receiving continuous children's mental health targeted case management services as defined in section 245.2875, subdivision 8.

Sec. 5. Minnesota Statutes 2024, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 142D.15 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with emotional disturbances or severe emotional disturbances who are at risk of residential treatment or hospitalization, who are already in out-of-home placement in family foster settings as defined in chapter 142B and at risk of change in out-of-home placement or placement in a residential facility or other higher level of care, who have utilized crisis services or emergency room services, or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners; ~~and~~

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants; and

(19) evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Sec. 6. Minnesota Statutes 2024, section 245.4905, is amended to read:

245.4905 FIRST EPISODE OF PSYCHOSIS AND EARLY EPISODE OF BIPOLAR DISORDER GRANT PROGRAM.

Subdivision 1. ~~**Creation**~~ **Establishment.** The commissioner of human services must establish the first episode of psychosis and early episode of bipolar disorder grant program ~~is established in the Department of Human Services~~ within the department to fund: (1) evidence-based interventions for youth and young adults at risk of developing or experiencing a first episode of psychosis or an early episode of bipolar disorder; and (2) a public awareness campaign on the signs and symptoms of psychosis. ~~First episode of psychosis services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clause (15)~~ For purposes of this section, "youth and young adults" means individuals who are 15 years of age or older and under 41 years of age.

Subd. 2. **Activities.** (a) All first episode of psychosis ~~grant programs~~ or early episode of bipolar disorder grantees must:

(1) provide intensive treatment and support for ~~adolescents and~~ youth and young adults experiencing or at risk of experiencing a first ~~psychotic~~ episode of psychosis or early episodes of bipolar disorder. Intensive treatment and support ~~includes~~ may include medication management, psychoeducation for an individual and an individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer and family peer support, crisis planning, and stress management;

(2) conduct outreach and provide training and guidance to mental health and health care professionals, including postsecondary health clinicians, on early psychosis and bipolar disorder symptoms, screening tools, and best practices;

(3) ensure access for individuals to first ~~psychotic~~ episode of psychosis services under this section, including access for individuals who live in rural areas; and

(4) use all available funding streams.

(b) Grant money may ~~also~~ be used to pay for housing or travel expenses for individuals receiving services or to address other barriers preventing individuals and their families from participating in first ~~psychotic~~ episode of psychosis services.

Subd. 3. ~~**Eligibility**~~ **Funding.** ~~Program activities must be provided to people 15 to 40 years old with early signs of psychosis~~ First episode of psychosis services and early episode of bipolar disorder services are eligible for children's mental health grants as specified in section 245.4889, subdivision 1, paragraph (b), clauses (16) and (19).

Subd. 4. **Outcomes.** (a) The commissioner must annually evaluate the first episode of psychosis and early episode of bipolar disorder grant program.

(b) The evaluation ~~of program activities~~ must utilize evidence-based practices and must include the following outcome evaluation criteria:

(1) whether individuals experience a reduction in ~~psychotic~~ symptoms;

(2) whether individuals experience a decrease in inpatient mental health hospitalizations or interactions with the criminal justice system; and

(3) whether individuals experience an increase in educational attainment or employment.

(c) By July 1, 2026, and every July 1 thereafter, the commissioner must provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over behavioral health, along with the chairs and ranking minority members of the senate

finance committee and house of representatives ways and means committee. The report must include the number of grantees receiving funds under this section, the number of individuals served under this section, data from the evaluation conducted under this subdivision, and information on the use of state and federal funds for the services provided under this section.

Subd. 5. **Federal aid or grants.** The commissioner of human services must comply with all conditions and requirements necessary to receive federal aid or grants.

Sec. 7. **MENTAL HEALTH COLLABORATION HUB INNOVATION PILOT PROGRAM.**

(a) The commissioner of human services must support the Mental Health Collaboration Hub's pilot project to develop and implement innovative care pathways and care facility decompression strategies by providing funding support and technical assistance and entering into a data sharing agreement with the Mental Health Collaboration Hub. The pilot project must fund, track, and evaluate activities that expedite transitions of children from inappropriate care settings to appropriate care settings. A steering committee of expert Mental Health Collaboration Hub participants that represent the continuum of children's behavioral health care must guide funding determinations to support the transition of up to 200 children per year.

(b) On January 1, 2027, and each January 1 for the subsequent four years, the Mental Health Collaboration Hub must submit a report to the commissioner and chairs and ranking minority members of the legislative committees with jurisdiction over children's mental health and juvenile detention. The report must describe how the grant funds were spent and summarize the impact the pilot project had on participating children, families, and providers.

Sec. 8. **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY REPORT.**

(a) By January 15, 2026, the commissioner of human services, in consultation with organizations operating psychiatric residential treatment facilities, advocates, health care experts, juvenile detention experts, and county representatives, must submit a report and proposed legislative changes to the chairs and ranking minority members of the legislative committees with jurisdiction over children's mental health and juvenile detention. The submitted report must include recommendations on:

(1) amending the state medical assistance plan to expand access to care provided in psychiatric residential treatment facilities, with consideration being given to enhancing flexibilities to serve a continuum of mental health needs;

(2) developing licensing standards for psychiatric residential treatment facilities that reflect needed flexibilities and the broad inclusion of settings where care can be delivered; and

(3) updating the rate methodology for services provided in psychiatric residential treatment facilities to assure high quality of care with required individualization.

(b) When developing the recommendations required under paragraph (b), the commissioner must:

(1) consider how best to meet the needs of children with high levels of complexity, aggression, and other related barriers to being served by community providers; and

(2) determine what would be required, including needed infrastructure, staffing, and sustainable funding sources, to allow qualified residential treatment programs to transition to a psychiatric residential treatment facility standard of care.

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

ARTICLE 9
BEHAVIORAL HEALTH POLICY

Section 1. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules,

parts 9530.6510 to 9530.6590. For purposes of all subdivisions except subdivisions 20, 28, 29, 32, and 33, resident also means a person who is admitted to a facility licensed to provide intensive residential treatment services or residential crisis stabilization under section 245I.23.

Sec. 2. Minnesota Statutes 2024, section 245.462, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. A case manager who is not a mental health practitioner ~~and~~ or who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree or with a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to ~~(3)~~ (5):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; ~~or~~

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section.;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of adults with serious and persistent mental illness that is consistent with national practice standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of adults with serious and persistent mental illness, consistent with national practice standards.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive ~~at least 40 hours of~~ annual continuing education in mental illness and mental health services ~~annually; and~~ according to the following schedule, based on years of service as a case management associate:

(i) at least 40 hours in the first year;

(ii) at least 30 hours in the second year;

(iii) at least 20 hours in the third year; and

(iv) at least 20 hours in the fourth year; and

(3) receive at least ~~five~~ four hours of ~~mentoring~~ supervision per ~~week~~ month from a case management ~~mentor~~ supervisor.

~~A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of~~

~~case manager associates. At least two mentoring hours per week must be individual and face-to-face.~~

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

Sec. 3. Minnesota Statutes 2024, section 245.462, subdivision 20, is amended to read:

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of enrolling in case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone ~~two~~ one or more episodes of inpatient, residential, or crisis residential care for a mental illness within the preceding ~~24~~ 12 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, posttraumatic stress disorder, generalized anxiety disorder, panic disorder, eating disorder, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), or the need for in-home services to remain in one's home, unless ongoing case management or community support services are provided;

(5) the adult has, in the last ~~three~~ five years, been committed by a court as a person ~~who is mentally ill~~ with a mental illness under chapter 253B, or the adult's commitment has been stayed or continued; or

~~(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; or~~

~~(7)~~ (6) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger.

(d) For purposes of enrolling in case management and community support services, a "person with a complex post-traumatic stress disorder" or "C-PTSD" means an adult who has a mental illness and meets the following criteria:

(1) the adult has post-traumatic stress disorder (PTSD) symptoms that significantly interfere with daily functioning related to intergenerational trauma, racial trauma, or unresolved historical grief; and

(2) the adult has a written opinion from a mental health professional that includes documentation of:

(i) culturally sensitive assessments or screenings and identification of intergenerational trauma, racial trauma, or unresolved historical grief;

(ii) significant impairment in functioning due to the PTSD symptoms that meet C-PTSD condition eligibility; and

(iii) increasing concerns within the last three years that indicates the adult is at a reasonable likelihood of experiencing significant episodes of PTSD with increased frequency, impacting daily functioning unless mitigated by targeted case management or community support services.

(e) Adults may continue to receive case management or community support services if, in the written opinion of a mental health professional, the person needs case management or community support services to maintain the person's recovery.

EFFECTIVE DATE. Paragraph (d) is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2024, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) In addition, the following are eligible for grant funds:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services, including the purchase and renovation of vehicles by mobile crisis teams in order to provide protected transport under section 256B.0625, subdivision 17, paragraph (l), clause (6);

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management; and

(20) transportation.

Sec. 5. Minnesota Statutes 2024, section 245.467, subdivision 4, is amended to read:

Subd. 4. **Referral for case management.** Each provider of emergency services, day treatment services, outpatient treatment, community support services, residential treatment, acute care hospital inpatient treatment, or regional treatment center inpatient treatment must inform each of its clients with serious and persistent mental illness or a complex post-traumatic stress disorder of the availability and potential benefits to the client of case management. If the client consents, the provider must refer the client by notifying the county employee designated by the county board to coordinate case management activities of the client's name and address and by informing the client of whom to contact to request case management. The provider must document compliance with this subdivision in the client's record.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2024, section 245.469, is amended to read:

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. Clients must not be charged for services provided. Emergency service providers must ~~not delay the timely provision of emergency services to a client because of the unwillingness or inability of the client to pay for services~~ meet the qualifications under

section 256B.0624, subdivision 4. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of each client;

(2) minimize further deterioration of each client;

(3) help each client to obtain ongoing care and treatment;

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults or children with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, clinical trainee, or mental health practitioner.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Subd. 3. **Mental health crisis services.** The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) ~~develop a central phone number where calls can be routed to the appropriate crisis services~~ promote the 988 Lifeline;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards and requirements for crisis services as outlined in section 256B.0624; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis

residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

Sec. 7. Minnesota Statutes 2024, section 245.4711, subdivision 1, is amended to read:

Subdivision 1. **Availability of case management services.** (a) ~~By January 1, 1989,~~ The county board shall provide case management services for all adults with serious and persistent mental illness or a complex post-traumatic stress disorder who are residents of the county and who request or consent to the services and to each adult for whom the court appoints a case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.462, subdivision 4.

(b) Case management services provided to adults with serious and persistent mental illness or a complex post-traumatic stress disorder eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs associated with mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2024, section 245.4711, subdivision 4, is amended to read:

Subd. 4. **Individual community support plan.** (a) The case manager must develop an individual community support plan for each adult that incorporates the client's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual community support plan. The individual community support plan must be developed within 30 days of client intake and reviewed at least every 180 days after it is developed, unless the case manager receives a written request from the client or the client's family for a review of the plan every 90 days after it is developed. The case manager is responsible for developing the individual community support plan based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery

of services according to the individual community support plan. To the extent possible, the adult with serious and persistent mental illness or a complex post-traumatic stress disorder, the person's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual community support plan.

(b) The client's individual community support plan must state:

(1) the goals of each service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual community support plan.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2024, section 245.4712, subdivision 1, is amended to read:

Subdivision 1. **Availability of community support services.** (a) County boards must provide or contract for sufficient community support services within the county to meet the needs of adults with serious and persistent mental illness or a complex post-traumatic stress disorder who are residents of the county. Adults may be required to pay a fee according to section 245.481. The community support services program must be designed to improve the ability of adults with serious and persistent mental illness or a complex post-traumatic stress disorder to:

(1) find and maintain competitive employment;

(2) handle basic activities of daily living;

(3) participate in leisure time activities;

(4) set goals and plans; and

(5) obtain and maintain appropriate living arrangements.

The community support services program must also be designed to reduce the need for and use of more intensive, costly, or restrictive placements both in number of admissions and length of stay.

(b) Community support services are those services that are supportive in nature and not necessarily treatment oriented, and include:

(1) conducting outreach activities such as home visits, health and wellness checks, and problem solving;

(2) connecting people to resources to meet their basic needs;

(3) finding, securing, and supporting people in their housing;

(4) attaining and maintaining health insurance benefits;

(5) assisting with job applications, finding and maintaining employment, and securing a stable financial situation;

(6) fostering social support, including support groups, mentoring, peer support, and other efforts to prevent isolation and promote recovery; and

(7) educating about mental illness, treatment, and recovery.

(c) Community support services shall use all available funding streams. The county shall maintain the level of expenditures for this program, as required under section 245.4835. County boards must continue to provide funds for those services not covered by other funding streams and to maintain an infrastructure to carry out these services. The county is encouraged to fund evidence-based practices such as Individual Placement and Supported Employment and Illness Management and Recovery.

(d) The commissioner shall collect data on community support services programs, including, but not limited to, demographic information such as age, sex, race, the number of people served, and information related to housing, employment, hospitalization, symptoms, and satisfaction with services.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2024, section 245.4712, subdivision 3, is amended to read:

Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious and persistent mental illness or a complex post-traumatic stress disorder in applying for state and federal benefits, including Supplemental Security Income, medical assistance, Medicare, general assistance, and Minnesota supplemental aid. The help must be offered as part of the community support program available to adults with serious and persistent mental illness or a complex post-traumatic stress disorder for whom the county is financially responsible and who may qualify for these benefits.

Sec. 11. Minnesota Statutes 2024, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager without a bachelor's degree, with a bachelor's degree that is not in one of the behavioral sciences or related fields, or who is not a mental health practitioner and does not have a bachelor's degree must meet one of the requirements in clauses (1) to ~~(3)~~ (5):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; ~~or~~

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section~~.~~;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of children with severe emotional disturbance, consistent with national practices standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of children with severe emotional disturbance, consistent with national practices standards.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with emotional disturbances; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

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

Sec. 12. Minnesota Statutes 2024, section 245.4871, is amended by adding a subdivision to read:

Subd. 7a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including oversight provided by the case manager. Clinical supervision must be provided by a mental health professional. The supervising mental health professional must cosign an individual treatment plan, and their name must be documented in the client's record.

Sec. 13. Minnesota Statutes 2024, section 245.4881, subdivision 3, is amended to read:

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, ~~and~~ monitor the provision of services, and if the child and parent or legal guardian consent, complete a written functional assessment as defined by section 245.4871, subdivision 18a. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The case manager shall note this provision in the child's record.

Sec. 14. Minnesota Statutes 2024, section 245.4901, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and services to students and their families, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including accessing needed mental health services to support the parent in caregiving and navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked behavioral health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Sec. 15. **[245.4904] INTERMEDIATE SCHOOL DISTRICT BEHAVIORAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to improve behavioral health outcomes for youth attending a qualifying school unit and to build the capacity of schools to support student and teacher needs in the classroom. For purposes of this section, "qualifying school unit" means an intermediate school district organized under section 136D.01.

Subd. 2. **Eligible applicants.** An eligible applicant is an intermediate school district organized under section 136D.01, and a partner entity or provider that has demonstrated capacity to serve the youth identified in subdivision 1 that is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943;

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.04, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families;

(6) licensed under chapter 245G and in compliance with the applicable requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544; or

(7) a licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 254B.05, subdivision 1, paragraph (b).

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses include but are not limited to:

(1) identifying mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and supportive services to students and their families within the classroom, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) delivering therapeutic interventions and customizing an array of supplementary learning experiences for students;

(4) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(5) providing transportation for students receiving behavioral health services when school is not in session;

(6) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(7) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. For purposes of this grant program, a third-party reimbursement

source does not include a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Calculating the share of the appropriation.** (a) Grants must be awarded to qualifying school units proportionately.

(b) The commissioner must calculate the share of the appropriation to be used in each qualifying school unit by multiplying the total appropriation going to the grantees by the qualifying school unit's average daily membership in a setting of federal instructional level 4 or higher and then dividing by the total average daily membership in a setting of federal instructional level 4 or higher for the same year for all qualifying school units.

Subd. 5. **Data collection and outcome measurement.** Grantees must provide data to the commissioner for the purpose of evaluating the Intermediate School District Behavioral Health Innovation grant program. The commissioner must consult with grantees to develop outcome measures for program capacity and performance.

Sec. 16. Minnesota Statutes 2024, section 245.4907, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training for mental health ~~certified~~ family peer ~~specialists~~ specialist candidates and continuing education to certified family peer specialists as specified in section 256B.0616, subdivision 5.

Sec. 17. Minnesota Statutes 2024, section 245.50, subdivision 3, is amended to read:

Subd. 3. **Exceptions.** A contract may not be entered into under this section for services to persons who:

(1) are serving a sentence after conviction of a criminal offense;

~~(2) are on probation or parole;~~

~~(3)~~ (2) are the subject of a presentence investigation; or

~~(4)~~ (3) have been committed involuntarily in Minnesota under chapter 253B for treatment of mental illness or chemical dependency, except as provided under subdivision 5.

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

Sec. 18. Minnesota Statutes 2024, section 245.50, is amended by adding a subdivision to read:

Subd. 6. **Contract notice.** A Minnesota mental health, chemical health, or detoxification agency or facility entering into a contract with a bordering state under this section must, within 30 days of the contract's effective date, provide the commissioner of human services with a copy of the contract. If the contract is amended, the agency or facility must provide the commissioner with a copy of each amendment within 30 days of the amendment's effective date.

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

Sec. 19. Minnesota Statutes 2024, section 245I.05, subdivision 3, is amended to read:

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, and physical and mental abilities.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner required to receive the training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects, including tardive dyskinesia.

(d) Within 90 days of first providing direct contact services to an adult client, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

Sec. 20. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

Subd. 5. **Additional training for medication administration.** (a) Prior to administering medications to a client under delegated authority or observing a client self-administer

medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects including tardive dyskinesia, and medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 21. Minnesota Statutes 2024, section 245I.06, subdivision 3, is amended to read:

Subd. 3. **Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral aide or a mental health rehabilitation worker must receive direct observation from a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner while the mental health behavioral aide or mental health rehabilitation worker provides treatment services to clients, no less than twice per month for the first six months of employment and once per month thereafter. ~~The staff person performing the direct observation must approve of the progress note for the observed treatment service.~~

(b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work must at a minimum consist of:

(1) monthly individual supervision; and

(2) direct observation twice per month.

Sec. 22. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

Subd. 5. **Medication administration in residential programs.** If a license holder is licensed as a residential program, the license holder must:

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

(2) monitor the effectiveness of medications, side effects of medications, and adverse reactions to medications, including symptoms and signs of tardive dyskinesia, for each client. The license holder must address and document any concerns about a client's medications;

(3) ensure that no staff person or client gives a legend drug supply for one client to another client;

(4) have policies and procedures for: (i) keeping a record of each client's medication orders; (ii) keeping a record of any incident of deferring a client's medications; (iii) documenting any incident when a client's medication is omitted; and (iv) documenting when a client refuses to take medications as prescribed; and

(5) document and track medication errors, document whether the license holder notified anyone about the medication error, determine if the license holder must take any follow-up actions, and identify the staff persons who are responsible for taking follow-up actions.

Sec. 23. Minnesota Statutes 2024, section 245I.12, subdivision 5, is amended to read:

Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure that:

(1) describes to clients how the license holder will meet the requirements in this subdivision; and

(2) contains the current public contact information of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health, Office of Health Facilities Complaints; and all applicable health-related licensing boards.

(b) On the day of each client's admission, the license holder must explain the grievance procedure to the client.

(c) The license holder must:

(1) post the grievance procedure in a place visible to clients and provide a copy of the grievance procedure upon request;

(2) allow clients, former clients, and their authorized representatives to submit a grievance to the license holder;

(3) within three business days of receiving a client's grievance, acknowledge in writing that the license holder received the client's grievance. If applicable, the license holder must include a notice of the client's separate appeal rights for a managed care organization's reduction, termination, or denial of a covered service;

(4) within 15 business days of receiving a client's grievance, provide a written final response to the client's grievance containing the license holder's official response to the grievance; and

(5) allow the client to bring a grievance to the person with the highest level of authority in the program.

(d) Clients may voice grievances and recommend changes in policies and services to staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge.

Sec. 24. Minnesota Statutes 2024, section 245I.23, subdivision 7, is amended to read:

Subd. 7. **Intensive residential treatment services assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of the client's admission, the license holder must complete an initial treatment plan for the client. The license holder must:

(1) base the client's initial treatment plan on the client's referral information and an assessment of the client's immediate needs;

(2) consider crisis assistance strategies that have been effective for the client in the past;

(3) identify the client's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the client engage in treatment;

(4) identify the participants involved in the client's treatment planning. The client must be a participant; and

(5) ensure that a treatment supervisor approves of the client's initial treatment plan if a mental health practitioner or clinical trainee completes the client's treatment plan, notwithstanding section 245I.08, subdivision 3.

(c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must complete an individual abuse prevention plan as part of a client's initial treatment plan.

(d) Within ~~five~~ ten days of the client's admission and again within 60 days after the client's admission, the license holder must complete a level of care assessment of the client. If the license holder determines that a client does not need a medically monitored level of service, a treatment supervisor must document how the client's admission to and continued services in intensive residential treatment services are medically necessary for the client.

(e) Within ten days of a client's admission, the license holder must complete or review and update the client's standard diagnostic assessment.

(f) Within ten days of a client's admission, the license holder must complete the client's individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days after the client's admission and again within 70 days after the client's admission, the license holder must update the client's individual treatment plan. The license holder must focus the client's treatment planning on preparing the client for a successful transition from intensive residential treatment services to another setting. In addition to the required elements of an individual treatment plan under section 245I.10, subdivision 8, the license holder must identify the following information in the client's individual treatment plan: (1) the client's referrals and resources for the client's health and safety; and (2) the staff persons who are responsible for following up with the client's referrals and resources. If the client does not receive a referral or resource that the client needs, the license holder must document the reason that the license holder did not make the referral or did not connect the client to a particular resource. The license holder is responsible for determining whether additional follow-up is required on behalf of the client.

(g) Within 30 days of the client's admission, the license holder must complete a functional assessment of the client. Within 60 days after the client's admission, the license holder must update the client's functional assessment to include any changes in the client's functioning and symptoms.

(h) For a client with a current substance use disorder diagnosis and for a client whose substance use disorder screening in the client's standard diagnostic assessment indicates the possibility that the client has a substance use disorder, the license holder must complete a written assessment of the client's substance use within 30 days of the client's admission. In

the substance use assessment, the license holder must: (1) evaluate the client's history of substance use, relapses, and hospitalizations related to substance use; (2) assess the effects of the client's substance use on the client's relationships including with family member and others; (3) identify financial problems, health issues, housing instability, and unemployment; (4) assess the client's legal problems, past and pending incarceration, violence, and victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking prescribed medications, and noncompliance with psychosocial treatment.

(i) On a weekly basis, a mental health professional or certified rehabilitation specialist must review each client's treatment plan and individual abuse prevention plan. The license holder must document in the client's file each weekly review of the client's treatment plan and individual abuse prevention plan.

Sec. 25. Minnesota Statutes 2024, section 256B.0616, subdivision 4, is amended to read:

Subd. 4. **Family peer support ~~specialist~~ program providers.** The commissioner shall develop a process to certify family peer support ~~specialist~~ programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Sec. 26. Minnesota Statutes 2024, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** (a) The commissioner shall develop ~~a~~ or approve the use of an existing training and certification process for ~~certified~~ certifying family peer specialists. ~~The~~ Family peer specialist candidates must have raised or be currently raising a child with a mental illness, have ~~had~~ experience navigating the children's mental health system, and ~~must~~ demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer ~~specialists~~ specialist candidates specific skills relevant to providing peer support to other parents and youth.

(b) In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

(c) Initial training leading to certification as a family peer specialist and continuing education for certified family peer specialists must be delivered by the commissioner or a third-party organization approved by the commissioner. An approved third-party organization may also provide continuing education of certified family peer specialists.

Sec. 27. Minnesota Statutes 2024, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

(1) have capacity to recruit, hire, manage, and train required ACT team members;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; ~~and~~

(6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services~~.~~; and

(7) ensure that overall treatment supervision to the ACT team is provided by a qualified member of the ACT team and is available during and after regular business hours and on weekends and holidays.

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 28. Minnesota Statutes 2024, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) ~~shall~~ must be a mental health professional~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role~~, clinical trainee, or mental health practitioner;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to ensure that overall treatment supervision to the ACT team is available after regular business hours and on weekends and holidays and is provided by a qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a mental health professional permitted to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical,

supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role; and

(vi) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) must not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include mental health professionals; clinical trainees; certified rehabilitation specialists; mental health practitioners; or mental health rehabilitation workers. These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 29. Minnesota Statutes 2024, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness, persons with a complex post-traumatic stress disorder, and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact either in person or by interactive

video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

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

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

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

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

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

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility,

as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

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

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 30. Minnesota Statutes 2024, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention, as defined in section 256B.0624, subdivision 2, paragraph (d).

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

Sec. 31. Laws 2023, chapter 70, article 20, section 2, subdivision 7, is amended to read:

Subd. 7. **Central Office; Behavioral Health, Deaf and Hard of Hearing, and Housing Services**

	Appropriations by Fund	
General	27,870,000	27,592,000
Lottery Prize	163,000	163,000

(a) **Homeless management system.** $250,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for a homeless management information system. The base for this appropriation is $1,140,000 in fiscal year 2026 and $1,140,000 in fiscal year 2027.

(b) **Online behavioral health program locator.** $959,000 in fiscal year 2024 and $959,000 in fiscal year 2025 are from the general fund for an online behavioral health program locator. Beginning July 1, 2025, any vendor of the online behavioral health program locator selected by the commissioner of human services to perform the duties under this paragraph must be based in Minnesota.

(c) **Integrated services for children and families.** $286,000 in fiscal year 2024 and $286,000 in fiscal year 2025 are from the general fund for integrated services for children and families projects. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, $1,797,000 of the appropriation in fiscal year 2024 is available until June 30, 2027.

(d) **Carryforward authority.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, $842,000 of the appropriation in fiscal year 2024 is available until June 30, 2027, and $852,000 of the appropriation in fiscal year 2025 is available until June 30, 2028.

(f) **Base level adjustment.** The general fund base is $25,243,000 in fiscal year 2026 and $24,682,000 in fiscal year 2027.

ARTICLE 10
CHILDREN'S MENTAL HEALTH TERMINOLOGY

Section 1. Minnesota Statutes 2024, section 62Q.527, subdivision 1, is amended to read:

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

~~(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.~~

~~(c)~~ (b) "Mental illness" has the meaning given in ~~section~~ sections 245.462, subdivision 20, paragraph (a), and 245.4871, subdivision 15.

~~(d)~~ (c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

Sec. 2. Minnesota Statutes 2024, section 62Q.527, subdivision 2, is amended to read:

Subd. 2. **Required coverage for antipsychotic drugs.** (a) A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat ~~emotional disturbance or~~ mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition.

(b) The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

(c) For drugs covered under this section, no health plan company that has received a certification from the health care provider as described in paragraph (a) may:

(1) impose a special deductible, co-payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(2) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Sec. 3. Minnesota Statutes 2024, section 62Q.527, subdivision 3, is amended to read:

Subd. 3. **Continuing care.** (a) Enrollees receiving a prescribed drug to treat a diagnosed mental illness ~~or emotional disturbance~~ may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, co-payment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(b) The continuing care benefit shall be extended annually when the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(c) The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

Sec. 4. Minnesota Statutes 2024, section 121A.61, subdivision 3, is amended to read:

Subd. 3. **Policy components.** The policy must include at least the following components:

(a) rules governing student conduct and procedures for informing students of the rules;

(b) the grounds for removal of a student from a class;

(c) the authority of the classroom teacher to remove students from the classroom pursuant to procedures and rules established in the district's policy;

(d) the procedures for removal of a student from a class by a teacher, school administrator, or other school district employee;

(e) the period of time for which a student may be removed from a class, which may not exceed five class periods for a violation of a rule of conduct;

(f) provisions relating to the responsibility for and custody of a student removed from a class;

(g) the procedures for return of a student to the specified class from which the student has been removed;

(h) the procedures for notifying a student and the student's parents or guardian of violations of the rules of conduct and of resulting disciplinary actions;

(i) any procedures determined appropriate for encouraging early involvement of parents or guardians in attempts to improve a student's behavior;

(j) any procedures determined appropriate for encouraging early detection of behavioral problems;

(k) any procedures determined appropriate for referring a student in need of special education services to those services;

(l) any procedures determined appropriate for ensuring victims of bullying who respond with behavior not allowed under the school's behavior policies have access to a remedial response, consistent with section 121A.031;

(m) the procedures for consideration of whether there is a need for a further assessment or of whether there is a need for a review of the adequacy of a current individualized education program of a student with a disability who is removed from class;

(n) procedures for detecting and addressing chemical abuse problems of a student while on the school premises;

(o) the minimum consequences for violations of the code of conduct;

(p) procedures for immediate and appropriate interventions tied to violations of the code;

(q) a provision that states that a teacher, school employee, school bus driver, or other agent of a district may use reasonable force in compliance with section 121A.582 and other laws;

(r) an agreement regarding procedures to coordinate crisis services to the extent funds are available with the county board responsible for implementing sections 245.487 to 245.4889 for students with a serious ~~emotional disturbance~~ mental illness or other students who have an individualized education program whose behavior may be addressed by crisis intervention;

(s) a provision that states a student must be removed from class immediately if the student engages in assault or violent behavior. For purposes of this paragraph, "assault" has the meaning given it in section 609.02, subdivision 10. The removal shall be for a period of time deemed appropriate by the principal, in consultation with the teacher;

(t) a prohibition on the use of exclusionary practices for early learners as defined in section 121A.425; and

(u) a prohibition on the use of exclusionary practices to address attendance and truancy issues.

Sec. 5. Minnesota Statutes 2024, section 128C.02, subdivision 5, is amended to read:

Subd. 5. **Rules for open enrollees.** (a) The league shall adopt league rules and regulations governing the athletic participation of pupils attending school in a nonresident district under section 124D.03.

(b) Notwithstanding other law or league rule or regulation to the contrary, when a student enrolls in or is readmitted to a recovery-focused high school after successfully completing a licensed program for treatment of alcohol or substance abuse~~,~~ or mental illness, ~~or emotional disturbance,~~ the student is immediately eligible to participate on the same basis as other district students in the league-sponsored activities of the student's resident school district. Nothing in this paragraph prohibits the league or school district from enforcing a league or district penalty resulting from the student violating a league or district rule.

(c) The league shall adopt league rules making a student with an individualized education program who transfers from one public school to another public school as a reasonable accommodation to reduce barriers to educational access immediately eligible to participate in league-sponsored varsity competition on the same basis as other students in the school to which the student transfers. The league also must establish guidelines, consistent with

this paragraph, for reviewing the 504 plan of a student who transfers between public schools to determine whether the student is immediately eligible to participate in league-sponsored varsity competition on the same basis as other students in the school to which the student transfers.

Sec. 6. Minnesota Statutes 2024, section 142G.02, subdivision 56, is amended to read:

Subd. 56. **Learning disabled.** "Learning disabled," for purposes of an extension to the 60-month time limit under section 142G.42, subdivision 4, clause (3), means the person has a disorder in one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. Learning disabled does not include learning problems that are primarily the result of visual, hearing, or motor disabilities; developmental disability; ~~emotional disturbance;~~ or mental illness or due to environmental, cultural, or economic disadvantage.

Sec. 7. Minnesota Statutes 2024, section 142G.27, subdivision 4, is amended to read:

Subd. 4. **Good cause exemptions for not attending orientation.** (a) The county agency shall not impose the sanction under section 142G.70 if it determines that the participant has good cause for failing to attend orientation. Good cause exists when:

(1) appropriate child care is not available;

(2) the participant is ill or injured;

(3) a family member is ill and needs care by the participant that prevents the participant from attending orientation. For a caregiver with a child or adult in the household who meets the disability or medical criteria for home care services under section 256B.0659, or a home and community-based waiver services program under chapter 256B, or meets the criteria for ~~severe emotional disturbance~~ serious mental illness under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when an interruption in the provision of those services occurs which prevents the participant from attending orientation;

(4) the caregiver is unable to secure necessary transportation;

(5) the caregiver is in an emergency situation that prevents orientation attendance;

(6) the orientation conflicts with the caregiver's work, training, or school schedule; or

(7) the caregiver documents other verifiable impediments to orientation attendance beyond the caregiver's control.

(b) Counties must work with clients to provide child care and transportation necessary to ensure a caregiver has every opportunity to attend orientation.

Sec. 8. Minnesota Statutes 2024, section 142G.42, subdivision 3, is amended to read:

Subd. 3. **Ill or incapacitated.** (a) An assistance unit subject to the time limit in section 142G.40, subdivision 1, is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) participants who are suffering from an illness, injury, or incapacity which has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment. These participants must follow the treatment recommendations of the qualified professional certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required as a caregiver because of the illness, injury, or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for a person to provide assistance in the home has been certified by a qualified professional and is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0651, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for ~~severe emotional disturbance~~ serious mental illness under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or maintaining suitable employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3).

Sec. 9. Minnesota Statutes 2024, section 245.462, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. A case manager who is not a mental health practitioner and who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; ~~or~~ as a child had ~~severe emotional disturbance~~ a serious mental illness as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive at least 40 hours of continuing education in mental illness and mental health services annually; and

(3) receive at least five hours of mentoring per week from a case management mentor.

A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

Sec. 10. Minnesota Statutes 2024, section 245.4682, subdivision 3, is amended to read:

Subd. 3. **Projects for coordination of care.** (a) Consistent with section 256B.69 and chapter 256L, the commissioner is authorized to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner shall require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the service area. Counties shall retain responsibility and authority for social services in these locally defined partnerships.

(b) The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the projects and use those criteria to solicit proposals for preferred integrated networks. The commissioner must develop criteria to evaluate the partnership proposed by the county and prepaid health plan to coordinate access and delivery of services. The proposal must at a minimum address how the partnership will coordinate the provision of:

(i) client outreach and identification of health and social service needs paired with expedited access to appropriate resources;

(ii) activities to maintain continuity of health care coverage;

(iii) children's residential mental health treatment and treatment foster care;

(iv) court-ordered assessments and treatments;

(v) prepetition screening and commitments under chapter 253B;

(vi) assessment and treatment of children identified through mental health screening of child welfare and juvenile corrections cases;

(vii) home and community-based waiver services;

(viii) assistance with finding and maintaining employment;

(ix) housing; and

(x) transportation;

(2) determine specifications for contracts with prepaid health plans to improve the plan's ability to serve persons with mental health conditions, including specifications addressing:

(i) early identification and intervention of physical and behavioral health problems;

(ii) communication between the enrollee and the health plan;

(iii) facilitation of enrollment for persons who are also eligible for a Medicare special needs plan offered by the health plan;

(iv) risk screening procedures;

(v) health care coordination;

(vi) member services and access to applicable protections and appeal processes;

(vii) specialty provider networks;

(viii) transportation services;

(ix) treatment planning; and

(x) administrative simplification for providers;

(3) begin implementation of the projects no earlier than January 1, 2009, with not more than 40 percent of the statewide population included during calendar year 2009 and additional counties included in subsequent years;

(4) waive any administrative rule not consistent with the implementation of the projects;

(5) allow potential bidders at least 90 days to respond to the request for proposals; and

(6) conduct an independent evaluation to determine if mental health outcomes have improved in that county or counties according to measurable standards designed in consultation with the advisory body established under this subdivision and reviewed by the State Advisory Council on Mental Health.

(c) Notwithstanding any statute or administrative rule to the contrary, the commissioner may enroll all persons eligible for medical assistance with serious mental illness ~~or emotional disturbance~~ in the prepaid plan of their choice within the project service area unless:

(1) the individual is eligible for home and community-based services for persons with developmental disabilities and related conditions under section 256B.092; or

(2) the individual has a basis for exclusion from the prepaid plan under section 256B.69, subdivision 4, other than disability, or mental illness~~, or emotional disturbance~~.

(d) The commissioner shall involve organizations representing persons with mental illness and their families in the development and distribution of information used to educate potential enrollees regarding their options for health care and mental health service delivery under this subdivision.

(e) If the person described in paragraph (c) does not elect to remain in fee-for-service medical assistance, or declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the preferred integrated network. The commissioner shall implement the enrollment changes within a project's service area on the timeline specified in that project's approved application.

(f) A person enrolled in a prepaid health plan under paragraphs (c) and (d) may disenroll from the plan at any time.

(g) The commissioner, in consultation with consumers, families, and their representatives, shall evaluate the projects begun in 2009, and shall refine the design of the service integration

projects before expanding the projects. The commissioner shall report to the chairs of the legislative committees with jurisdiction over mental health services by March 1, 2008, on plans for evaluation of preferred integrated networks established under this subdivision.

(h) The commissioner shall apply for any federal waivers necessary to implement these changes.

(i) Payment for Medicaid service providers under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

Sec. 11. Minnesota Statutes 2024, section 245.4835, subdivision 2, is amended to read:

Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

(b) The commissioner shall consider the following factors to determine whether to approve a county's corrective action plan:

(1) the degree to which a county is maximizing revenues for mental health services from noncounty sources;

(2) the degree to which a county is expanding use of alternative services that meet mental health needs, but do not count as mental health services within existing reporting systems. If approved by the commissioner, the alternative services must be included in the county's base as well as subsequent years. The commissioner's approval for alternative services must be based on the following criteria:

(i) the service must be provided to children ~~with emotional disturbance~~ or adults with mental illness;

(ii) the services must be based on an individual treatment plan or individual community support plan as defined in the Comprehensive Mental Health Act; and

(iii) the services must be supervised by a mental health professional and provided by staff who meet the staff qualifications defined in sections 256B.0943, subdivision 7, and 256B.0623, subdivision 5.

(c) Additional county expenditures to make up for the prior year's underspending may be spread out over a two-year period.

Sec. 12. Minnesota Statutes 2024, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform substance use disorder assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment to identify whether the client may have co-occurring mental health and substance use disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and ~~either~~ a serious mental illness ~~or emotional disturbance~~.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 13. Minnesota Statutes 2024, section 245.487, subdivision 2, is amended to read:

Subd. 2. **Findings.** The legislature finds there is a need for further development of existing clinical services for ~~emotionally disturbed~~ children with mental illness and their families and the creation of new services for this population. Although the services specified

in sections 245.487 to 245.4889 are mental health services, sections 245.487 to 245.4889 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for continuity of care with other community agencies. At the same time, sections 245.487 to 245.4889 emphasize the importance of developing special mental health expertise in children's mental health services because of the unique needs of this population.

Nothing in sections 245.487 to 245.4889 shall be construed to abridge the authority of the court to make dispositions under chapter 260, but the mental health services due any child with serious and persistent mental illness, as defined in section 245.462, subdivision 20, or with ~~severe emotional disturbance~~ serious mental illness, as defined in section 245.4871, subdivision 6, shall be made a part of any disposition affecting that child.

Sec. 14. Minnesota Statutes 2024, section 245.4871, subdivision 3, is amended to read:

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with ~~severe emotional disturbance~~ serious mental illness and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

Sec. 15. Minnesota Statutes 2024, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with ~~severe emotional disturbance~~ serious mental illness and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with ~~emotional disturbance~~ mental illness must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with ~~severe emotional~~

~~disturbance~~ serious mental illness before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in ~~severe emotional disturbance~~ serious mental illness and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious ~~emotional disturbance~~ mental illness as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with ~~emotional disturbances~~ mental illness; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals

meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in ~~severe emotional disturbance~~ serious mental illness and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with ~~severe emotional disturbance~~ serious mental illness of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 16. Minnesota Statutes 2024, section 245.4871, subdivision 6, is amended to read:

Subd. 6. **Child with ~~severe emotional disturbance~~ serious mental illness.** For purposes of eligibility for case management and family community support services, "child with ~~severe emotional disturbance~~ serious mental illness" means a child who has ~~an emotional disturbance~~ mental illness and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for ~~an emotional disturbance~~ mental illness; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for ~~an emotional disturbance~~ mental illness through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of ~~an emotional disturbance~~ mental illness; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of ~~an emotional disturbance~~ mental illness, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Sec. 17. Minnesota Statutes 2024, section 245.4871, subdivision 13, is amended to read:

Subd. 13. **Education and prevention services.** (a) "Education and prevention services" means services designed to:

(1) educate the general public;

(2) increase the understanding and acceptance of problems associated with ~~emotional disturbances~~ children's mental illnesses;

(3) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning; and

(4) refer specific children or their families with mental health needs to mental health services.

(b) The services include distribution to individuals and agencies identified by the county board and the local children's mental health advisory council of information on predictors and symptoms of ~~emotional disturbances~~ mental illnesses, where mental health services are available in the county, and how to access the services.

Sec. 18. Minnesota Statutes 2024, section 245.4871, subdivision 15, is amended to read:

Subd. 15. **~~Emotional disturbance~~ Mental illness.** ~~"Emotional disturbance"~~ "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is detailed in a diagnostic codes list published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

~~"Emotional disturbance"~~ Mental illness is a generic term and is intended to reflect all categories of disorder described in the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."

Sec. 19. Minnesota Statutes 2024, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the treatment supervision of a mental health professional and designed to help each child with ~~severe emotional disturbance~~ serious mental illness to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with ~~severe emotional disturbance~~ serious mental illness and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with ~~severe emotional disturbance~~ serious mental illness;

(5) assistance with leisure and recreational activities;

(6) crisis planning, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 20. Minnesota Statutes 2024, section 245.4871, subdivision 19, is amended to read:

Subd. 19. **Individual family community support plan.** "Individual family community support plan" means a written plan developed by a case manager in conjunction with the family and the child with ~~severe emotional disturbance~~ serious mental illness on the basis of a diagnostic assessment and a functional assessment. The plan identifies specific services needed by a child and the child's family to:

(1) treat the symptoms and dysfunctions determined in the diagnostic assessment;

(2) relieve conditions leading to ~~emotional disturbance~~ mental illness and improve the personal well-being of the child;

(3) improve family functioning;

(4) enhance daily living skills;

(5) improve functioning in education and recreation settings;

(6) improve interpersonal and family relationships;

(7) enhance vocational development; and

(8) assist in obtaining transportation, housing, health services, and employment.

Sec. 21. Minnesota Statutes 2024, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** (a) "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

(b) A children's residential facility licensed under Minnesota Rules, chapter 2960, is exempt from the requirements of section 245I.10, subdivisions 7 and 8. Instead, the individual treatment plan must:

(1) include a written plan of intervention, treatment, and services for a child with ~~an~~ ~~emotional disturbance~~ mental illness that the service provider develops under the clinical supervision of a mental health professional on the basis of a diagnostic assessment;

(2) be developed in conjunction with the family unless clinically inappropriate; and

(3) identify goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with ~~an emotional disturbance~~ mental illness.

Sec. 22. Minnesota Statutes 2024, section 245.4871, subdivision 22, is amended to read:

Subd. 22. **Legal representative.** "Legal representative" means a guardian, conservator, or guardian ad litem of a child with ~~an emotional disturbance~~ mental illness authorized by the court to make decisions about mental health services for the child.

Sec. 23. Minnesota Statutes 2024, section 245.4871, subdivision 28, is amended to read:

Subd. 28. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to children with ~~emotional disturbances~~ mental illnesses and are described in sections 245.487 to 245.4889.

Sec. 24. Minnesota Statutes 2024, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the treatment supervision of a mental health professional to children with ~~emotional disturbances~~ mental illnesses who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 25. Minnesota Statutes 2024, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** (a) "Professional home-based family treatment" means intensive mental health services provided to children because of ~~an emotional disturbance~~ mental illness: (1) who are at risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care; (2) who are in ~~out-of-home placement~~ residential treatment or therapeutic foster care; or (3) who are returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care.

(b) Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health

needs of the child and the child's family. Services must be coordinated with other services provided to the child and the child's family.

(c) Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 26. Minnesota Statutes 2024, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with ~~emotional disturbances~~ mental illnesses under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 27. Minnesota Statutes 2024, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and treatment supervision provided by a mental health professional to foster families caring for children with ~~severe emotional disturbance~~ serious mental illnesses to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 28. Minnesota Statutes 2024, section 245.4873, subdivision 2, is amended to read:

Subd. 2. **State level; coordination.** The Children's Cabinet, under section 4.045, in consultation with a representative of the Minnesota District Judges Association Juvenile Committee, shall:

(1) educate each agency about the policies, procedures, funding, and services for children with ~~emotional disturbances~~ mental illnesses of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with ~~emotional disturbances~~ mental illnesses;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent; and

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children.

Sec. 29. Minnesota Statutes 2024, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(6) provide for case management services to each child with ~~severe emotional disturbance~~ serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility~~, acute care hospital inpatient treatment, or informal admission to a regional treatment center~~;

(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in ~~out-of-home placement~~ residential treatment or foster care, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually

to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results are classified as private data on individuals, as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide the commissioner with access to the screening results for the purposes of program evaluation and improvement.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 30. Minnesota Statutes 2024, section 245.4875, subdivision 5, is amended to read:

Subd. 5. **Local children's advisory council.** (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be

included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with ~~severe emotional disturbance~~ serious mental illness; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with ~~emotional disturbance~~ mental illness in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county.

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Sec. 31. Minnesota Statutes 2024, section 245.4876, subdivision 4, is amended to read:

Subd. 4. **Referral for case management.** Each provider of emergency services, outpatient treatment, community support services, family community support services, day treatment services, screening under section 245.4885, professional home-based family treatment services, residential treatment facilities, acute care hospital inpatient treatment facilities, or regional treatment center services must inform each child with ~~severe emotional disturbance~~ serious mental illness, and the child's parent or legal representative, of the availability and potential benefits to the child of case management. The information shall be provided as specified in subdivision 5. If consent is obtained according to subdivision 5, the provider

must refer the child by notifying the county employee designated by the county board to coordinate case management activities of the child's name and address and by informing the child's family of whom to contact to request case management. The provider must document compliance with this subdivision in the child's record. The parent or child may directly request case management even if there has been no referral.

Sec. 32. Minnesota Statutes 2024, section 245.4876, subdivision 5, is amended to read:

Subd. 5. **Consent for services or for release of information.** (a) Although sections 245.487 to 245.4889 require each county board, within the limits of available resources, to make the mental health services listed in those sections available to each child residing in the county who needs them, the county board shall not provide any services, either directly or by contract, unless consent to the services is obtained under this subdivision. The case manager assigned to a child with a ~~severe emotional disturbance~~ serious mental illness shall not disclose to any person other than the case manager's immediate supervisor and the mental health professional providing clinical supervision of the case manager information on the child, the child's family, or services provided to the child or the child's family without informed written consent unless required to do so by statute or under the Minnesota Government Data Practices Act. Informed written consent must comply with section 13.05, subdivision 4, paragraph (d), and specify the purpose and use for which the case manager may disclose the information.

(b) The consent or authorization must be obtained from the child's parent unless: (1) the parental rights are terminated; or (2) consent is otherwise provided under sections 144.341 to 144.347; 253B.04, subdivision 1; 260C.148; 260C.151; and 260C.201, subdivision 1, the terms of appointment of a court-appointed guardian or conservator, or federal regulations governing substance use disorder services.

Sec. 33. Minnesota Statutes 2024, section 245.4877, is amended to read:

245.4877 EDUCATION AND PREVENTION SERVICES.

Education and prevention services must be available to all children residing in the county. Education and prevention services must be designed to:

(1) convey information regarding ~~emotional disturbances~~ mental illness, mental health needs, and treatment resources to the general public;

(2) at least annually, distribute to individuals and agencies identified by the county board and the local children's mental health advisory council information on predictors and

symptoms of ~~emotional disturbances~~ mental illness, where mental health services are available in the county, and how to access the services;

(3) increase understanding and acceptance of problems associated with ~~emotional disturbances~~ mental illness;

(4) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning;

(5) prevent development or deepening of ~~emotional disturbances~~ mental illness; and

(6) refer each child with ~~emotional disturbance~~ mental illness or the child's family with additional mental health needs to appropriate mental health services.

Sec. 34. Minnesota Statutes 2024, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with ~~emotional disturbance~~ mental illness residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health clinics meeting the standards of chapter 245I; by contract with privately operated mental health clinics meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a mental health professional. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Sec. 35. Minnesota Statutes 2024, section 245.488, subdivision 3, is amended to read:

Subd. 3. **Mental health crisis services.** County boards must provide or contract for mental health crisis services within the county to meet the needs of children with ~~emotional disturbance~~ mental illness residing in the county who are determined, through an assessment by a mental health professional, to be experiencing a mental health crisis or mental health emergency. The mental health crisis services provided must be medically necessary, as defined in section 62Q.53, subdivision 2, and necessary for the safety of the child or others regardless of the setting.

Sec. 36. Minnesota Statutes 2024, section 245.4881, subdivision 1, is amended to read:

Subdivision 1. **Availability of case management services.** (a) The county board shall provide case management services for each child with ~~severe emotional disturbance~~ serious mental illness who is a resident of the county and the child's family who request or consent to the services. Case management services must be offered to a child with a serious ~~emotional disturbance~~ mental illness who is over the age of 18 consistent with section 245.4875, subdivision 8, or the child's legal representative, provided the child's service needs can be met within the children's service system. Before discontinuing case management services under this subdivision for children between the ages of 17 and 21, a transition plan must be developed. The transition plan must be developed with the child and, with the consent of a child age 18 or over, the child's parent, guardian, or legal representative. The transition plan should include plans for health insurance, housing, education, employment, and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Except as permitted by law and the commissioner under demonstration projects, case management services provided to children with ~~severe emotional disturbance~~ serious mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs of mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Sec. 37. Minnesota Statutes 2024, section 245.4881, subdivision 4, is amended to read:

Subd. 4. **Individual family community support plan.** (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan at least every 180 calendar days after it is developed, unless the case manager has received a written request from the child's family or an advocate for the child for a review of the plan every 90 days after it is developed. To the extent appropriate, the child with ~~severe emotional disturbance~~ serious mental illness, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of an individual family community support plan, the case manager shall assist the child and child's family in accessing the needed services listed in section 245.4884, subdivision 1.

(b) The child's individual family community support plan must state:

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual family community support plan.

Sec. 38. Minnesota Statutes 2024, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be reviewed every 90 days. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) help the child improve family living and social interaction skills;

(2) help the child gain the necessary skills to return to the community;

(3) stabilize crisis admissions; and

(4) work with families throughout the placement to improve the ability of the families to care for children with ~~severe emotional disturbance~~ serious mental illness in the home.

Sec. 39. Minnesota Statutes 2024, section 245.4882, subdivision 5, is amended to read:

Subd. 5. **Specialized residential treatment services.** The commissioner of human services shall continue efforts to further interagency collaboration to develop a comprehensive system of services, including family community support and specialized residential treatment services for children. The services shall be designed for children with ~~emotional disturbance~~ mental illness who exhibit violent or destructive behavior and for whom local treatment services are not feasible due to the small number of children statewide who need the services and the specialized nature of the services required. The services shall be located in community settings.

Sec. 40. Minnesota Statutes 2024, section 245.4884, is amended to read:

245.4884 FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. **Availability of family community support services.** By July 1, 1991, county boards must provide or contract for sufficient family community support services within the county to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness who resides in the county and the child's family. Children or their parents may be required to pay a fee in accordance with section 245.481.

Family community support services must be designed to improve the ability of children with ~~severe emotional disturbance~~ serious mental illness to:

(1) manage basic activities of daily living;

(2) function appropriately in home, school, and community settings;

(3) participate in leisure time or community youth activities;

(4) set goals and plans;

(5) reside with the family in the community;

(6) participate in after-school and summer activities;

(7) make a smooth transition among mental health and education services provided to children; and

(8) make a smooth transition into the adult mental health system as appropriate.

In addition, family community support services must be designed to improve overall family functioning if clinically appropriate to the child's needs, and to reduce the need for and use of placements more intensive, costly, or restrictive both in the number of admissions and lengths of stay than indicated by the child's diagnostic assessment.

The commissioner of human services shall work with mental health professionals to develop standards for clinical supervision of family community support services. These standards shall be incorporated in rule and in guidelines for grants for family community support services.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be part of the family community support services available to each child with ~~severe emotional disturbance~~ serious mental illness residing in the county. A child or the child's parent may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placements that are more intensive, costly, or restrictive than necessary to meet the child's need;

(4) coordinate with or be offered in conjunction with the child's education program;

(5) provide therapy and family intervention for children that are coordinated with education services provided and funded by schools; and

(6) operate during all 12 months of the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) alternative services exist through the county's family community support services for each child who would otherwise need day treatment services; and

(2) county demographics and geography make the provision of day treatment services cost ineffective and unfeasible.

Subd. 3. **Professional home-based family treatment provided.** (a) By January 1, 1991, county boards must provide or contract for sufficient professional home-based family treatment within the county to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness who is at risk of ~~out-of-home placement~~ residential treatment or

therapeutic foster care due to the child's ~~emotional disturbance~~ mental illness or who is returning to the home from ~~out-of-home placement~~ residential treatment or therapeutic foster care. The child or the child's parent may be required to pay a fee according to section 245.481. The county board shall require that all service providers of professional home-based family treatment set fee schedules approved by the county board that are based on the child's or family's ability to pay. The professional home-based family treatment must be designed to assist each child with ~~severe emotional disturbance~~ serious mental illness who is at risk of or who is returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care and the child's family to:

(1) improve overall family functioning in all areas of life;

(2) treat the child's symptoms of ~~emotional disturbance~~ mental illness that contribute to a risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(3) provide a positive change in the emotional, behavioral, and mental well-being of children and their families; and

(4) reduce risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care for the identified child with ~~severe emotional disturbance~~ serious mental illness and other siblings or successfully reunify and reintegrate into the family a child returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care due to ~~emotional disturbance~~ mental illness.

(b) Professional home-based family treatment must be provided by a team consisting of a mental health professional and others who are skilled in the delivery of mental health services to children and families in conjunction with other human service providers. The professional home-based family treatment team must maintain flexible hours of service availability and must provide or arrange for crisis services for each family, 24 hours a day, seven days a week. Case loads for each professional home-based family treatment team must be small enough to permit the delivery of intensive services and to meet the needs of the family. Professional home-based family treatment providers shall coordinate services and service needs with case managers assigned to children and their families. The treatment team must develop an individual treatment plan that identifies the specific treatment objectives for both the child and the family.

Subd. 4. **Therapeutic support of foster care.** By January 1, 1992, county boards must provide or contract for foster care with therapeutic support as defined in section 245.4871, subdivision 34. Foster families caring for children with ~~severe emotional disturbance~~ serious

mental illness must receive training and supportive services, as necessary, at no cost to the foster families within the limits of available resources.

Subd. 5. **Benefits assistance.** The county board must offer help to a child with ~~severe emotional disturbance~~ serious mental illness and the child's family in applying for federal benefits, including Supplemental Security Income, medical assistance, and Medicare.

Sec. 41. Minnesota Statutes 2024, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of ~~severe emotional disturbance~~ serious mental illness in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if county funds are used to pay for the child's services. An emergency includes when a child is in need of and has been referred for crisis stabilization services under section 245.4882, subdivision 6. A child who has been referred to residential treatment for crisis stabilization services in a residential treatment center is not required to undergo an assessment under this section.

(b) The county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's needs.

(d) When a level of care determination is conducted, the county board or other entity may not determine that a screening of a child, referral, or admission to a residential treatment facility is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

(f) The level of care determination, placement decision, and recommendations for mental health services must be documented in the child's record and made available to the child's family, as appropriate.

Sec. 42. Minnesota Statutes 2024, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 142D.15 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with ~~emotional disturbances~~ mental illness as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with ~~emotional disturbances~~ mental illness or ~~severe emotional disturbances~~ serious mental illness who are at risk of residential treatment or hospitalization~~,~~; who are already in ~~out-of-home placement~~ residential treatment, therapeutic foster care, or in family foster settings as defined in chapter 142B and at risk of change in ~~out-of-home placement~~ foster care or placement in a residential facility or other higher level of care~~,~~; who have utilized crisis services or emergency room services~~,~~; or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners; and

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Sec. 43. Minnesota Statutes 2024, section 245.4907, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that employs a mental health certified peer family specialist qualified under section 245I.04, subdivision 12, and that provides services to families who have a child:

(1) with ~~an emotional disturbance~~ mental illness or ~~severe emotional disturbance~~ serious mental illness under chapter 245;

(2) receiving inpatient hospitalization under section 256B.0625, subdivision 1;

(3) admitted to a residential treatment facility under section 245.4882;

(4) receiving children's intensive behavioral health services under section 256B.0946;

(5) receiving day treatment or children's therapeutic services and supports under section 256B.0943; or

(6) receiving crisis response services under section 256B.0624.

Sec. 44. Minnesota Statutes 2024, section 245.491, subdivision 2, is amended to read:

Subd. 2. **Purpose.** The legislature finds that children with mental illnesses or emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and employment and economic development. In order to better meet the needs of these children, it is the intent of the legislature to establish an integrated children's mental health service system that:

(1) allows local service decision makers to draw funding from a single local source so that funds follow clients and eliminates the need to match clients, funds, services, and provider eligibilities;

(2) creates a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;

(3) improves the efficiency of use of existing resources;

(4) minimizes or eliminates the incentives for cost and risk shifting; and

(5) increases the incentives for earlier identification and intervention.

The children's mental health integrated fund established under sections 245.491 to 245.495 must be used to develop and support this integrated mental health service system. In developing this integrated service system, it is not the intent of the legislature to limit any rights available to children and their families through existing federal and state laws.

Sec. 45. Minnesota Statutes 2024, section 245.492, subdivision 3, is amended to read:

Subd. 3. **Children with emotional or behavioral disturbances.** "Children with emotional or behavioral disturbances" includes children with ~~emotional disturbances~~ mental illnesses as defined in section 245.4871, subdivision 15, and children with emotional or behavioral disorders as defined in Minnesota Rules, part 3525.1329, subpart 1.

Sec. 46. Minnesota Statutes 2024, section 245.697, subdivision 2a, is amended to read:

Subd. 2a. **Subcommittee on Children's Mental Health.** The State Advisory Council on Mental Health (the "advisory council") must have a Subcommittee on Children's Mental Health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

(1) the commissioners or designees of the commissioners of the Departments of Human Services, Health, Education, State Planning, and Corrections;

(2) a designee of the Direct Care and Treatment executive board;

(3) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;

(4) at least one representative of an advocacy group for children with ~~emotional disturbances~~ mental illnesses;

(5) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;

(6) parents of children who have ~~emotional disturbances~~ mental illnesses;

(7) a present or former consumer of adolescent mental health services;

(8) educators currently working with ~~emotionally disturbed~~ children with mental illnesses;

(9) people knowledgeable about the needs of ~~emotionally disturbed~~ children with mental illnesses of minority races and cultures;

(10) people experienced in working with ~~emotionally disturbed~~ children with mental illnesses who have committed status offenses;

(11) members of the advisory council;

(12) one person from the local corrections department and one representative of the Minnesota District Judges Association Juvenile Committee; and

(13) county commissioners and social services agency representatives.

The chair of the advisory council shall appoint subcommittee members described in clauses (4) to (12) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance on the subcommittee. Terms, compensation, removal, and filling of vacancies are governed by subdivision 1, except that terms of

subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Sec. 47. Minnesota Statutes 2024, section 245.814, subdivision 3, is amended to read:

Subd. 3. **Compensation provisions.** (a) If the commissioner of human services is unable to obtain insurance through ordinary methods for coverage of foster home providers, the appropriation shall be returned to the general fund and the state shall pay claims subject to the following limitations.

~~(a)~~ (b) Compensation shall be provided only for injuries, damage, or actions set forth in subdivision 1.

~~(b)~~ (c) Compensation shall be subject to the conditions and exclusions set forth in subdivision 2.

~~(c)~~ (d) The state shall provide compensation for bodily injury, property damage, or personal injury resulting from the foster home providers activities as a foster home provider while the foster child or adult is in the care, custody, and control of the foster home provider in an amount not to exceed $250,000 for each occurrence.

~~(d)~~ (e) The state shall provide compensation for damage or destruction of property caused or sustained by a foster child or adult in an amount not to exceed $250 for each occurrence.

~~(e)~~ (f) The compensation in paragraphs ~~(c) and~~ (d) and (e) is the total obligation for all damages because of each occurrence regardless of the number of claims made in connection with the same occurrence, but compensation applies separately to each foster home. The state shall have no other responsibility to provide compensation for any injury or loss caused or sustained by any foster home provider or foster child or foster adult.

(g) This coverage is extended as a benefit to foster home providers to encourage care of persons who need ~~out-of-home~~ the providers' care. Nothing in this section shall be construed to mean that foster home providers are agents or employees of the state nor does the state accept any responsibility for the selection, monitoring, supervision, or control of foster home providers which is exclusively the responsibility of the counties which shall regulate foster home providers in the manner set forth in the rules of the commissioner of human services.

Sec. 48. Minnesota Statutes 2024, section 245.826, is amended to read:

245.826 USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES IN FACILITIES SERVING ~~EMOTIONALLY DISTURBED~~ CHILDREN WITH MENTAL ILLNESSES.

When amending rules governing facilities serving ~~emotionally disturbed~~ children with mental illnesses that are licensed under section 245A.09 and Minnesota Rules, parts 2960.0510 to 2960.0530 and 2960.0580 to 2960.0700, the commissioner of human services shall include provisions governing the use of restrictive techniques and procedures. No provision of these rules may encourage or require the use of restrictive techniques and procedures. The rules must prohibit: (1) the application of certain restrictive techniques or procedures in facilities, except as authorized in the child's case plan and monitored by the county caseworker responsible for the child; (2) the use of restrictive techniques or procedures that restrict the clients' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of corporal punishment. The rule may specify other restrictive techniques and procedures and the specific conditions under which permitted techniques and procedures are to be carried out.

Sec. 49. Minnesota Statutes 2024, section 245.91, subdivision 2, is amended to read:

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state Departments of Human Services, Direct Care and Treatment, Health, and Education, and of local school districts and designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~.

Sec. 50. Minnesota Statutes 2024, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency, facility, or program that provides services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; a sober home as defined in section 254B.01, subdivision 11; peer recovery support services provided by a recovery community organization as defined in section 254B.01, subdivision 8; and

an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~.

Sec. 51. Minnesota Statutes 2024, section 245.92, is amended to read:

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information and data about decisions, acts, and other matters of an agency, facility, or program, and shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

Sec. 52. Minnesota Statutes 2024, section 245.94, subdivision 1, is amended to read:

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman is a health oversight agency as defined in Code of Federal Regulations, title 45, section 164.501. The ombudsman may access patient records according to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph, "records" has the meaning given in Code of Federal Regulations, title 42, section 2.53(a)(1)(i).

(c) The ombudsman may mediate or advocate on behalf of a client.

(d) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients.

(e) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of one or more clients who may not be capable of requesting assistance have been adversely affected, the ombudsman may gather

information and data about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(f) The ombudsman may gather, on behalf of one or more clients, records of an agency, facility, or program, or records related to clinical drug trials from the University of Minnesota Department of Psychiatry, if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program. The ombudsman may also take photographic or videographic evidence while reviewing the actions of an agency, facility, or program, with the consent of the client. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~. All data collected, created, received, or maintained by the ombudsman are governed by chapter 13 and other applicable law.

(g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(h) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(i) The ombudsman may attend Direct Care and Treatment Review Board and Special Review Board proceedings; proceedings regarding the transfer of clients, as defined in section 246.50, subdivision 4, between institutions operated by the Direct Care and Treatment executive board; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(j) The ombudsman shall gather data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services

provided to clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(l) The Office of Ombudsman shall provide the services of the Civil Commitment Training and Resource Center.

(m) The ombudsman shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial and ensure that all protections for human subjects required by federal law and the Institutional Review Board are provided.

(n) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Sec. 53. Minnesota Statutes 2024, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not misuse substances or have a substance use disorder, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or substance use disorder treatment;

(9) programs licensed by the commissioner of corrections;

(10) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(11) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(12) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(13) residential programs for persons with mental illness, that are located in hospitals;

(14) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(15) mental health outpatient services for adults with mental illness or children with ~~emotional disturbance~~ mental illness;

(16) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(17) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(18) assisted living facilities licensed by the commissioner of health under chapter 144G;

(19) substance use disorder treatment activities of licensed professionals in private practice as defined in section 245G.01, subdivision 17;

(20) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service;

(21) a county that is an eligible vendor under section 254B.05 to provide care coordination and comprehensive assessment services;

(22) a recovery community organization that is an eligible vendor under section 254B.05 to provide peer recovery support services; or

(23) programs licensed by the commissioner of children, youth, and families in chapter 142B.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 54. Minnesota Statutes 2024, section 245A.26, subdivision 1, is amended to read:

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

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "License holder" means an individual, organization, or government entity that was issued a license by the commissioner of human services under this chapter for residential mental health treatment for children with ~~emotional disturbance~~ mental illness according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700, or shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(d) "Mental health professional" means an individual who is qualified under section 245I.04, subdivision 2.

Sec. 55. Minnesota Statutes 2024, section 245A.26, subdivision 2, is amended to read:

Subd. 2. **Scope and applicability.** (a) This section establishes additional licensing requirements for a children's residential facility to provide children's residential crisis

stabilization services to a client who is experiencing a mental health crisis and is in need of residential treatment services.

(b) A children's residential facility may provide residential crisis stabilization services only if the facility is licensed to provide:

(1) residential mental health treatment for children with ~~emotional disturbance~~ mental illness according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700; or

(2) shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(c) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (1), the facility is not required to complete a diagnostic assessment or treatment plan under Minnesota Rules, part 2960.0180, subpart 2, and part 2960.0600.

(d) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (2), the facility is not required to develop a plan for meeting the client's immediate needs under Minnesota Rules, part 2960.0520, subpart 3.

Sec. 56. Minnesota Statutes 2024, section 246C.12, subdivision 4, is amended to read:

Subd. 4. **Staff safety training.** The executive board shall require all staff in mental health and support units at regional treatment centers who have contact with ~~persons~~ children or adults with mental illness ~~or severe emotional disturbance~~ to be appropriately trained in violence reduction and violence prevention and shall establish criteria for such training. Training programs shall be developed with input from consumer advocacy organizations and shall employ violence prevention techniques as preferable to physical interaction.

Sec. 57. Minnesota Statutes 2024, section 252.27, subdivision 1, is amended to read:

Subdivision 1. **County of financial responsibility.** Whenever any child who has a developmental disability, or a physical disability or ~~emotional disturbance~~ mental illness is in 24-hour care outside the home including respite care, in a facility licensed by the commissioner of human services, the cost of services shall be paid by the county of financial responsibility determined pursuant to chapter 256G. If the child's parents or guardians do not reside in this state, the cost shall be paid by the responsible governmental agency in the

state from which the child came, by the parents or guardians of the child if they are financially able, or, if no other payment source is available, by the commissioner of human services.

Sec. 58. Minnesota Statutes 2024, section 256B.02, subdivision 11, is amended to read:

Subd. 11. **Related condition.** "Related condition" means a condition:

(1) that is found to be closely related to a developmental disability, including but not limited to cerebral palsy, epilepsy, autism, fetal alcohol spectrum disorder, and Prader-Willi syndrome; and

(2) that meets all of the following criteria:

(i) is severe and chronic;

(ii) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilities;

(iii) requires treatment or services similar to those required for persons with developmental disabilities;

(iv) is manifested before the person reaches 22 years of age;

(v) is likely to continue indefinitely;

(vi) results in substantial functional limitations in three or more of the following areas of major life activity:

(A) self-care;

(B) understanding and use of language;

(C) learning;

(D) mobility;

(E) self-direction; or

(F) capacity for independent living; and

(vii) is not attributable to mental illness as defined in section 245.462, subdivision 20, or ~~an emotional disturbance as defined in section~~ 245.4871, subdivision 15. For purposes of this item, notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15, "mental illness" does not include autism or other pervasive developmental disorders.

Sec. 59. Minnesota Statutes 2024, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious ~~emotional disturbance~~ mental illness requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic

developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by (1) the parent or guardian, (2) the child's physician or physicians, advanced practice registered nurse or advanced practice registered nurses, or physician assistant or physician assistants, and (3)

other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

Sec. 60. Minnesota Statutes 2024, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have ~~an emotional disturbance~~ mental illness or ~~severe emotional disturbance~~ serious mental illness under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 61. Minnesota Statutes 2024, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home models in accordance with United States Code, title 42, section 1396w-4.

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has a condition that meets the definition of mental illness as described in section 245.462, subdivision 20, paragraph (a), or ~~emotional disturbance as defined in section~~ 245.4871, subdivision 15, clause (2). The commissioner shall establish criteria for determining continued eligibility.

Sec. 62. Minnesota Statutes 2024, section 256B.0943, subdivision 1, is amended to read:

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

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed ~~emotional disturbance, as defined in section 245.4871, subdivision 15, or a diagnosed~~ mental illness, as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

(g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client

and the client's family or providing covered services through telehealth as defined under section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

~~(i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.~~

~~(j)~~ (i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

~~(k)~~ (j) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

~~(l)~~ (k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

~~(m)~~ (l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

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

~~(o)~~ (n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

~~(p)~~ (o) "Mental illness~~,~~" ~~for persons at least age 18 but under age 21,~~ has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given in section 245.4871, subdivision 15, for children under 18 years of age.

~~(q)~~ (p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

~~(r)~~ (q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

~~(s)~~ (r) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

~~(t)~~ (s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

~~(u)~~ (t) "Treatment supervision" means the supervision described in section 245I.06.

Sec. 63. Minnesota Statutes 2024, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a clinical trainee that is performed within one year before the initial start of service and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

(1) determine whether a child under age 18 has a diagnosis of ~~emotional disturbance~~ mental illness or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals; and

(3) be used in the development of the individual treatment plan.

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

(c) Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.

Sec. 64. Minnesota Statutes 2024, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a team under the treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the

client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

(iv) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(v) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with ~~an emotional disturbance or~~ a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan.

Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

Sec. 65. Minnesota Statutes 2024, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time, unless one service is delivered to the child and the other service is delivered to the child's family or treatment team without the child present;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's ~~emotional disturbance~~ mental illness;

(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

Sec. 66. Minnesota Statutes 2024, section 256B.0943, subdivision 13, is amended to read:

Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with ~~severe emotional disturbance~~ serious mental illness who is residing in a hospital; a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential treatment facility under section 256B.0625, subdivision 45a; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

Sec. 67. Minnesota Statutes 2024, section 256B.0945, subdivision 1, is amended to read:

Subdivision 1. **Residential services; provider qualifications.** (a) Counties must arrange to provide residential services for children with ~~severe emotional disturbance~~ serious mental illness according to sections 245.4882, 245.4885, and this section.

(b) Services must be provided by a facility that is licensed according to section 245.4882 and administrative rules promulgated thereunder, and under contract with the county.

(c) Eligible service costs may be claimed for a facility that is located in a state that borders Minnesota if:

(1) the facility is the closest facility to the child's home, providing the appropriate level of care; and

(2) the commissioner of human services has completed an inspection of the out-of-state program according to the interagency agreement with the commissioner of corrections under section 260B.198, subdivision 11, paragraph (b), and the program has been certified by the commissioner of corrections under section 260B.198, subdivision 11, paragraph (a), to substantially meet the standards applicable to children's residential mental health treatment programs under Minnesota Rules, chapter 2960. Nothing in this section requires the commissioner of human services to enforce the background study requirements under chapter 245C or the requirements related to prevention and investigation of alleged maltreatment under section 626.557 or chapter 260E. Complaints received by the commissioner of human services must be referred to the out-of-state licensing authority for possible follow-up.

(d) Notwithstanding paragraph (b), eligible service costs may be claimed for an out-of-state inpatient treatment facility if:

(1) the facility specializes in providing mental health services to children who are deaf, deafblind, or hard-of-hearing and who use American Sign Language as their first language;

(2) the facility is licensed by the state in which it is located; and

(3) the state in which the facility is located is a member state of the Interstate Compact on Mental Health.

Sec. 68. Minnesota Statutes 2024, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of children's intensive behavioral health services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph ~~(l)~~ (j);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) medical assistance room and board rate, as defined in section 256B.056, subdivision 5d.

Sec. 69. Minnesota Statutes 2024, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities that are covered by a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph ~~(u)~~ (r);

(3) crisis planning as defined in section 245.4871, subdivision 9a;

(4) medication management provided by a physician, an advanced practice registered nurse with certification in psychiatric and mental health care, or a physician assistant;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0624;

(11) transition services;

(12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

(13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity: client access to crisis

intervention services, as defined in section 256B.0624, and available 24 hours per day and seven days per week.

Sec. 70. Minnesota Statutes 2024, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly persons and persons with a disability.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly persons with a disability, or persons with a disability only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious ~~emotional disturbance~~ mental illness in children, the commissioner

must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious ~~emotional disturbance,~~ mental illness in children without approval of the county board of the county in which the demonstration is being implemented.

(b) MS 2009 Supplement [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]

(c) Before implementation of a demonstration project for persons with a disability, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community access for disability inclusion or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the

state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract year 2010 for services provided under the community access for disability inclusion waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. Effective January 1, 2011, enrollment and operation of the MnDHO program in effect during 2010 shall cease. The commissioner may reopen the program provided all applicable conditions of this section are met. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans to reopen MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance prior to implementation.

(g) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 71. Minnesota Statutes 2024, section 256B.77, subdivision 7a, is amended to read:

Subd. 7a. **Eligible individuals.** (a) Persons are eligible for the demonstration project as provided in this subdivision.

(b) "Eligible individuals" means those persons living in the demonstration site who are eligible for medical assistance and are disabled based on a disability determination under section 256B.055, subdivisions 7 and 12, or who are eligible for medical assistance and have been diagnosed as having:

(1) serious and persistent mental illness as defined in section 245.462, subdivision 20;

(2) ~~severe emotional disturbance~~ serious mental illness as defined in section 245.4871, subdivision 6; or

(3) developmental disability, or being a person with a developmental disability as defined in section 252A.02, or a related condition as defined in section 256B.02, subdivision 11.

Other individuals may be included at the option of the county authority based on agreement with the commissioner.

(c) Eligible individuals include individuals in excluded time status, as defined in chapter 256G. Enrollees in excluded time at the time of enrollment shall remain in excluded time status as long as they live in the demonstration site and shall be eligible for 90 days after placement outside the demonstration site if they move to excluded time status in a county within Minnesota other than their county of financial responsibility.

(d) A person who is a sexual psychopathic personality as defined in section 253D.02, subdivision 15, or a sexually dangerous person as defined in section 253D.02, subdivision 16, is excluded from enrollment in the demonstration project.

Sec. 72. Minnesota Statutes 2024, section 260B.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The local social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team, which may be the team constituted under section 245.4885 or 256B.092 or chapter 254B, shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability. The team shall involve parents or guardians in the screening process as appropriate. The team may be the same team as defined in section 260C.157, subdivision 3.

(b) If the court, prior to~~,~~ or as part of~~,~~ a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness, and residential placement is consistent with section 260.012, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a post-dispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall notify the county welfare agency. The county's juvenile treatment screening team must either:

(i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or

(ii) elect not to screen a given case, and notify the court of that decision within three working days.

(c) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

Sec. 73. Minnesota Statutes 2024, section 260C.007, subdivision 16, is amended to read:

Subd. 16. **~~Emotionally disturbed~~ Mental illness.** "~~Emotionally disturbed~~ Mental illness" means ~~emotional disturbance~~ mental illness as described in section 245.4871, subdivision 15.

Sec. 74. Minnesota Statutes 2024, section 260C.007, subdivision 26d, is amended to read:

Subd. 26d. **Qualified residential treatment program.** "Qualified residential treatment program" means a children's residential treatment program licensed under chapter 245A or licensed or approved by a tribe that is approved to receive foster care maintenance payments under section 142A.418 that:

(1) has a trauma-informed treatment model designed to address the needs of children with serious emotional or behavioral disorders or disturbances or mental illnesses;

(2) has registered or licensed nursing staff and other licensed clinical staff who:

(i) provide care within the scope of their practice; and

(ii) are available 24 hours per day and seven days per week;

(3) is accredited by any of the following independent, nonprofit organizations: the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Council on Accreditation (COA), or any other nonprofit accrediting organization approved by the United States Department of Health and Human Services;

(4) if it is in the child's best interests, facilitates participation of the child's family members in the child's treatment programming consistent with the child's out-of-home placement plan under sections 260C.212, subdivision 1, and 260C.708;

(5) facilitates outreach to family members of the child, including siblings;

(6) documents how the facility facilitates outreach to the child's parents and relatives, as well as documents the child's parents' and other relatives' contact information;

(7) documents how the facility includes family members in the child's treatment process, including after the child's discharge, and how the facility maintains the child's sibling connections; and

(8) provides the child and child's family with discharge planning and family-based aftercare support for at least six months after the child's discharge. Aftercare support may include clinical care consultation under section 256B.0671, subdivision 7, and mental health certified family peer specialist services under section 256B.0616.

Sec. 75. Minnesota Statutes 2024, section 260C.007, subdivision 27b, is amended to read:

Subd. 27b. **Residential treatment facility.** "Residential treatment facility" means a 24-hour-a-day program that provides treatment for children with ~~emotional disturbance~~ mental illness, consistent with section 245.4871, subdivision 32, and includes a licensed residential program specializing in caring 24 hours a day for children with a developmental delay or related condition. A residential treatment facility does not include a psychiatric residential treatment facility under section 256B.0941 or a family foster home as defined in section 260C.007, subdivision 16b.

Sec. 76. Minnesota Statutes 2024, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter and chapter 260D, for a child to receive treatment for ~~an emotional disturbance~~ a mental illness, ~~a~~ developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a tribe. A screening team is not required for a child to be in: (1) a residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; (3) supervised settings for youth who are 18 years of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885, 254B.05, or 256B.092. The team shall consist of social workers; persons with expertise in the treatment of juveniles who are emotionally disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, and, if applicable, the child's tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted

effort to include a designated representative of the Indian child's tribe on the juvenile treatment screening team, unless the child's tribal authority declines to appoint a representative. The Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with ~~an emotional disturbance or~~ a mental illness, developmental disability, or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and permanency team under section 260C.706. Prior to notifying relatives regarding the family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is age 14 or older, and, if applicable, the child's tribe to ensure that the agency is providing notice to individuals who will act in the child's best interests. The child and the child's parents may identify a culturally competent qualified individual to complete the child's assessment. The agency shall make efforts to refer the assessment to the identified qualified individual. The assessment may not be delayed for the purpose of having the assessment completed by a specific qualified individual.

(f) When a screening team determines that a child does not need treatment in a qualified residential treatment program, the screening team must:

(1) document the services and supports that will prevent the child's foster care placement and will support the child remaining at home;

(2) document the services and supports that the agency will arrange to place the child in a family foster home; or

(3) document the services and supports that the agency has provided in any other setting.

(g) When the Indian child's tribe or tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness, a developmental disability, or co-occurring ~~emotional disturbance~~ mental illness and chemical dependency, the Indian child's tribe or the tribe delegated by the child's tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's tribe to designate a representative to the screening team.

(h) The responsible social services agency must conduct and document the screening in a format approved by the commissioner of human services.

Sec. 77. Minnesota Statutes 2024, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection or services or neglected and in foster care, the court shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, the father must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in the father's home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; or

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In making a foster care placement of a child whose custody has been transferred under this subdivision, the agency shall make an individualized determination of how the placement is in the child's best interests using the placement consideration order for relatives and the best interest factors in section 260C.212, subdivision 2, and may include a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190; or

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means that the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit in order to protect the child's health, safety, or welfare and may remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order that describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or commence permanency proceedings under sections 260C.503 to 260C.515. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months;

(4) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental disability or ~~emotional disturbance~~ mental illness as defined in section 245.4871, subdivision 15, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(5) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child as defined in paragraph (f).

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency to monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

(f) For the purposes of this subdivision, "alternative safe living arrangement" means a living arrangement for a child proposed by a petitioning parent or guardian if a court excludes the minor from the parent's or guardian's home that is separate from the victim of domestic abuse and safe for the child respondent. A living arrangement proposed by a petitioning parent or guardian is presumed to be an alternative safe living arrangement absent information to the contrary presented to the court. In evaluating any proposed living arrangement, the court shall consider whether the arrangement provides the child with necessary food, clothing, shelter, and education in a safe environment. Any proposed living arrangement that would place the child in the care of an adult who has been physically or sexually violent is presumed unsafe.

Sec. 78. Minnesota Statutes 2024, section 260C.201, subdivision 2, is amended to read:

Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section shall contain written findings of fact to support the disposition and case plan ordered and shall also set forth in writing the following information:

(1) why the best interests and safety of the child are served by the disposition and case plan ordered;

(2) what alternative dispositions or services under the case plan were considered by the court and why such dispositions or services were not appropriate in the instant case;

(3) when legal custody of the child is transferred, the appropriateness of the particular placement made or to be made by the placing agency using the relative and sibling placement considerations and best interest factors in section 260C.212, subdivision 2, or the appropriateness of a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190;

(4) whether reasonable efforts to finalize the permanent plan for the child consistent with section 260.012 were made including reasonable efforts:

(i) to prevent the child's placement and to reunify the child with the parent or guardian from whom the child was removed at the earliest time consistent with the child's safety. The court's findings must include a brief description of what preventive and reunification efforts were made and why further efforts could not have prevented or eliminated the necessity of removal or that reasonable efforts were not required under section 260.012 or 260C.178, subdivision 1;

(ii) to identify and locate any noncustodial or nonresident parent of the child and to assess such parent's ability to provide day-to-day care of the child, and, where appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide day-to-day care of the child as required under section 260C.219, unless such services are not required under section 260.012 or 260C.178, subdivision 1. The court's findings must include a description of the agency's efforts to:

(A) identify and locate the child's noncustodial or nonresident parent;

(B) assess the noncustodial or nonresident parent's ability to provide day-to-day care of the child; and

(C) if appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide the child's day-to-day care, including efforts to engage the noncustodial or nonresident parent in assuming care and responsibility of the child;

(iii) to make the diligent search for relatives and provide the notices required under section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the agency has made diligent efforts to conduct a relative search and has appropriately engaged relatives who responded to the notice under section 260C.221 and other relatives, who came to the attention of the agency after notice under section 260C.221 was sent, in placement and case planning decisions fulfills the requirement of this item;

(iv) to identify and make a foster care placement of the child, considering the order in section 260C.212, subdivision 2, paragraph (a), in the home of an unlicensed relative, according to the requirements of section 142B.06, a licensed relative, or other licensed foster care provider, who will commit to being the permanent legal parent or custodian for the child in the event reunification cannot occur, but who will actively support the reunification plan for the child. If the court finds that the agency has not appropriately considered relatives for placement of the child, the court shall order the agency to comply with section 260C.212, subdivision 2, paragraph (a). The court may order the agency to continue considering relatives for placement of the child regardless of the child's current placement setting; and

(v) to place siblings together in the same home or to ensure visitation is occurring when siblings are separated in foster care placement and visitation is in the siblings' best interests under section 260C.212, subdivision 2, paragraph (d); and

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or ~~emotional disturbance~~ mental illness as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

(i) whether the child has mental health needs that must be addressed by the case plan;

(ii) what consideration was given to the diagnostic and functional assessments performed by the child's mental health professional and to health and mental health care professionals' treatment recommendations;

(iii) what consideration was given to the requests or preferences of the child's parent or guardian with regard to the child's interventions, services, or treatment; and

(iv) what consideration was given to the cultural appropriateness of the child's treatment or services.

(b) If the court finds that the social services agency's preventive or reunification efforts have not been reasonable but that further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(c) If the child has been identified by the responsible social services agency as the subject of concurrent permanency planning, the court shall review the reasonable efforts of the agency to develop a permanency plan for the child that includes a primary plan that is for reunification with the child's parent or guardian and a secondary plan that is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 79. Minnesota Statutes 2024, section 260C.301, subdivision 4, is amended to read:

Subd. 4. **Current foster care children.** Except for cases where the child is in placement due solely to the child's developmental disability or ~~emotional disturbance~~ mental illness, where custody has not been transferred to the responsible social services agency, and where the court finds compelling reasons to continue placement, the county attorney shall file a termination of parental rights petition or a petition to transfer permanent legal and physical custody to a relative under section 260C.515, subdivision 4, for all children who have been in out-of-home care for 15 of the most recent 22 months. This requirement does not apply

if there is a compelling reason approved by the court for determining that filing a termination of parental rights petition or other permanency petition would not be in the best interests of the child or if the responsible social services agency has not provided reasonable efforts necessary for the safe return of the child, if reasonable efforts are required.

Sec. 80. Minnesota Statutes 2024, section 260D.01, is amended to read:

260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

(a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care for treatment" provisions of the Juvenile Court Act.

(b) The juvenile court has original and exclusive jurisdiction over a child in voluntary foster care for treatment upon the filing of a report or petition required under this chapter. All obligations of the responsible social services agency to a child and family in foster care contained in chapter 260C not inconsistent with this chapter are also obligations of the agency with regard to a child in foster care for treatment under this chapter.

(c) This chapter shall be construed consistently with the mission of the children's mental health service system as set out in section 245.487, subdivision 3, and the duties of an agency under sections 256B.092 and 260C.157 and Minnesota Rules, parts 9525.0004 to 9525.0016, to meet the needs of a child with a developmental disability or related condition. This chapter:

(1) establishes voluntary foster care through a voluntary foster care agreement as the means for an agency and a parent to provide needed treatment when the child must be in foster care to receive necessary treatment for ~~an emotional disturbance or~~ a mental illness, developmental disability, or related condition;

(2) establishes court review requirements for a child in voluntary foster care for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or ~~a~~ related condition;

(3) establishes the ongoing responsibility of the parent as legal custodian to visit the child, to plan together with the agency for the child's treatment needs, to be available and accessible to the agency to make treatment decisions, and to obtain necessary medical, dental, and other care for the child;

(4) applies to voluntary foster care when the child's parent and the agency agree that the child's treatment needs require foster care either:

(i) due to a level of care determination by the agency's screening team informed by the child's diagnostic and functional assessment under section 245.4885; or

(ii) due to a determination regarding the level of services needed by the child by the responsible social services agency's screening team under section 256B.092, and Minnesota Rules, parts 9525.0004 to 9525.0016; and

(5) includes the requirements for a child's placement in sections 260C.70 to 260C.714, when the juvenile treatment screening team recommends placing a child in a qualified residential treatment program, except as modified by this chapter.

(d) This chapter does not apply when there is a current determination under chapter 260E that the child requires child protective services or when the child is in foster care for any reason other than treatment for the child's ~~emotional disturbance or~~ mental illness, developmental disability, or related condition. When there is a determination under chapter 260E that the child requires child protective services based on an assessment that there are safety and risk issues for the child that have not been mitigated through the parent's engagement in services or otherwise, or when the child is in foster care for any reason other than the child's ~~emotional disturbance or~~ mental illness, developmental disability, or related condition, the provisions of chapter 260C apply.

(e) The paramount consideration in all proceedings concerning a child in voluntary foster care for treatment is the safety, health, and the best interests of the child. The purpose of this chapter is:

(1) to ensure that a child with a disability is provided the services necessary to treat or ameliorate the symptoms of the child's disability;

(2) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, approving the child's placement away from the child's parents only when the child's need for care or treatment requires out-of-home placement and the child cannot be maintained in the home of the parent; and

(3) to ensure that the child's parent retains legal custody of the child and associated decision-making authority unless the child's parent willfully fails or is unable to make decisions that meet the child's safety, health, and best interests. The court may not find that the parent willfully fails or is unable to make decisions that meet the child's needs solely because the parent disagrees with the agency's choice of foster care facility, unless the agency files a petition under chapter 260C, and establishes by clear and convincing evidence that the child is in need of protection or services.

(f) The legal parent-child relationship shall be supported under this chapter by maintaining the parent's legal authority and responsibility for ongoing planning for the child and by the agency's assisting the parent, when necessary, to exercise the parent's ongoing right and obligation to visit or to have reasonable contact with the child. Ongoing planning means:

(1) actively participating in the planning and provision of educational services, medical, and dental care for the child;

(2) actively planning and participating with the agency and the foster care facility for the child's treatment needs;

(3) planning to meet the child's need for safety, stability, and permanency, and the child's need to stay connected to the child's family and community;

(4) engaging with the responsible social services agency to ensure that the family and permanency team under section 260C.706 consists of appropriate family members. For purposes of voluntary placement of a child in foster care for treatment under chapter 260D, prior to forming the child's family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's Tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals unless the individual is a treating professional or an important connection to the youth as outlined in the case or crisis plan; and

(5) for a voluntary placement under this chapter in a qualified residential treatment program, as defined in section 260C.007, subdivision 26d, for purposes of engaging in a relative search as provided in section 260C.221, the county agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's Tribe to obtain recommendations regarding which adult relatives the county agency should notify. If the child, child's parents, or legal guardians raise concerns about specific relatives, the county agency should not notify those relatives.

(g) The provisions of section 260.012 to ensure placement prevention, family reunification, and all active and reasonable effort requirements of that section apply.

Sec. 81. Minnesota Statutes 2024, section 260D.02, subdivision 5, is amended to read:

Subd. 5. **Child in voluntary foster care for treatment.** "Child in voluntary foster care for treatment" means a child with ~~emotional disturbance~~ a mental illness or developmental

disability~~,~~ or who has a related condition and is in foster care under a voluntary foster care agreement between the child's parent and the agency due to concurrence between the agency and the parent when it is determined that foster care is medically necessary:

(1) due to a determination by the agency's screening team based on its review of the diagnostic and functional assessment under section 245.4885; or

(2) due to a determination by the agency's screening team under section 256B.092 and Minnesota Rules, parts 9525.0004 to 9525.0016.

A child is not in voluntary foster care for treatment under this chapter when there is a current determination under chapter 260E that the child requires child protective services or when the child is in foster care for any reason other than the child's ~~emotional or~~ mental illness, developmental disability, or related condition.

Sec. 82. Minnesota Statutes 2024, section 260D.02, subdivision 9, is amended to read:

Subd. 9. **~~Emotional disturbance~~ Mental illness.** "~~Emotional disturbance~~ Mental illness" means ~~emotional disturbance~~ mental illness as described in section 245.4871, subdivision 15.

Sec. 83. Minnesota Statutes 2024, section 260D.03, subdivision 1, is amended to read:

Subdivision 1. **Voluntary foster care.** When the agency's screening team, based upon the diagnostic and functional assessment under section 245.4885 or medical necessity screenings under section 256B.092, subdivision 7, determines the child's need for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or related condition requires foster care placement of the child, a voluntary foster care agreement between the child's parent and the agency gives the agency legal authority to place the child in foster care.

Sec. 84. Minnesota Statutes 2024, section 260D.04, is amended to read:

260D.04 REQUIRED INFORMATION FOR A CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

An agency with authority to place a child in voluntary foster care for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or related condition~~,~~ shall inform the child, age 12 or older, of the following:

(1) the child has the right to be consulted in the preparation of the out-of-home placement plan required under section 260C.212, subdivision 1, and the administrative review required under section 260C.203;

(2) the child has the right to visit the parent and the right to visit the child's siblings as determined safe and appropriate by the parent and the agency;

(3) if the child disagrees with the foster care facility or services provided under the out-of-home placement plan required under section 260C.212, subdivision 1, the agency shall include information about the nature of the child's disagreement and, to the extent possible, the agency's understanding of the basis of the child's disagreement in the information provided to the court in the report required under section 260D.06; and

(4) the child has the rights established under Minnesota Rules, part 2960.0050, as a resident of a facility licensed by the state.

Sec. 85. Minnesota Statutes 2024, section 260D.06, subdivision 2, is amended to read:

Subd. 2. **Agency report to court; court review.** The agency shall obtain judicial review by reporting to the court according to the following procedures:

(a) A written report shall be forwarded to the court within 165 days of the date of the voluntary placement agreement. The written report shall contain or have attached:

(1) a statement of facts that necessitate the child's foster care placement;

(2) the child's name, date of birth, race, gender, and current address;

(3) the names, race, date of birth, residence, and post office addresses of the child's parents or legal custodian;

(4) a statement regarding the child's eligibility for membership or enrollment in an Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

(5) the names and addresses of the foster parents or chief administrator of the facility in which the child is placed, if the child is not in a family foster home or group home;

(6) a copy of the out-of-home placement plan required under section 260C.212, subdivision 1;

(7) a written summary of the proceedings of any administrative review required under section 260C.203;

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d; and

(9) any other information the agency, parent or legal custodian, the child or the foster parent, or other residential facility wants the court to consider.

(b) In the case of a child in placement due to ~~emotional disturbance~~ mental illness, the written report shall include as an attachment, the child's individual treatment plan developed by the child's treatment professional, as provided in section 245.4871, subdivision 21, or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(c) In the case of a child in placement due to developmental disability or a related condition, the written report shall include as an attachment, the child's individual service plan, as provided in section 256B.092, subdivision 1b; the child's individual program plan, as provided in Minnesota Rules, part 9525.0004, subpart 11; the child's waiver care plan; or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(d) The agency must inform the child, age 12 or older, the child's parent, and the foster parent or foster care facility of the reporting and court review requirements of this section and of their right to submit information to the court:

(1) if the child or the child's parent or the foster care provider wants to send information to the court, the agency shall advise those persons of the reporting date and the date by which the agency must receive the information they want forwarded to the court so the agency is timely able submit it with the agency's report required under this subdivision;

(2) the agency must also inform the child, age 12 or older, the child's parent, and the foster care facility that they have the right to be heard in person by the court and how to exercise that right;

(3) the agency must also inform the child, age 12 or older, the child's parent, and the foster care provider that an in-court hearing will be held if requested by the child, the parent, or the foster care provider; and

(4) if, at the time required for the report under this section, a child, age 12 or older, disagrees about the foster care facility or services provided under the out-of-home placement plan required under section 260C.212, subdivision 1, the agency shall include information regarding the child's disagreement, and to the extent possible, the basis for the child's disagreement in the report required under this section.

(e) After receiving the required report, the court has jurisdiction to make the following determinations and must do so within ten days of receiving the forwarded report, whether a hearing is requested:

(1) whether the voluntary foster care arrangement is in the child's best interests;

(2) whether the parent and agency are appropriately planning for the child; and

(3) in the case of a child age 12 or older, who disagrees with the foster care facility or services provided under the out-of-home placement plan, whether it is appropriate to appoint counsel and a guardian ad litem for the child using standards and procedures under section 260C.163.

(f) Unless requested by a parent, representative of the foster care facility, or the child, no in-court hearing is required in order for the court to make findings and issue an order as required in paragraph (e).

(g) If the court finds the voluntary foster care arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child, the court shall issue an order containing explicit, individualized findings to support its determination. The individualized findings shall be based on the agency's written report and other materials submitted to the court. The court may make this determination notwithstanding the child's disagreement, if any, reported under paragraph (d).

(h) The court shall send a copy of the order to the county attorney, the agency, parent, child, age 12 or older, and the foster parent or foster care facility.

(i) The court shall also send the parent, the child, age 12 or older, the foster parent, or representative of the foster care facility notice of the permanency review hearing required under section 260D.07, paragraph (e).

(j) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent are not appropriately planning for the child, the court shall notify the agency, the parent, the foster parent or foster care facility, the child, age 12 or older, and the county attorney of the court's determinations and the basis for the court's determinations. In this case, the court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

Sec. 86. Minnesota Statutes 2024, section 260D.07, is amended to read:

260D.07 REQUIRED PERMANENCY REVIEW HEARING.

(a) When the court has found that the voluntary arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child pursuant to the report submitted under section 260D.06, and the child continues in voluntary foster care as defined in section 260D.02, subdivision 10, for 13 months from the date of the voluntary foster care agreement, or has been in placement for 15 of the last 22 months, the agency must:

(1) terminate the voluntary foster care agreement and return the child home; or

(2) determine whether there are compelling reasons to continue the voluntary foster care arrangement and, if the agency determines there are compelling reasons, seek judicial approval of its determination; or

(3) file a petition for the termination of parental rights.

(b) When the agency is asking for the court's approval of its determination that there are compelling reasons to continue the child in the voluntary foster care arrangement, the agency shall file a "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" and ask the court to proceed under this section.

(c) The "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" shall be drafted or approved by the county attorney and be under oath. The petition shall include:

(1) the date of the voluntary placement agreement;

(2) whether the petition is due to the child's developmental disability or ~~emotional disturbance~~ mental illness;

(3) the plan for the ongoing care of the child and the parent's participation in the plan;

(4) a description of the parent's visitation and contact with the child;

(5) the date of the court finding that the foster care placement was in the best interests of the child, if required under section 260D.06, or the date the agency filed the motion under section 260D.09, paragraph (b);

(6) the agency's reasonable efforts to finalize the permanent plan for the child, including returning the child to the care of the child's family;

(7) a citation to this chapter as the basis for the petition; and

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(d) An updated copy of the out-of-home placement plan required under section 260C.212, subdivision 1, shall be filed with the petition.

(e) The court shall set the date for the permanency review hearing no later than 14 months after the child has been in placement or within 30 days of the petition filing date when the child has been in placement 15 of the last 22 months. The court shall serve the petition together with a notice of hearing by United States mail on the parent, the child age 12 or older, the child's guardian ad litem, if one has been appointed, the agency, the county attorney, and counsel for any party.

(f) The court shall conduct the permanency review hearing on the petition no later than 14 months after the date of the voluntary placement agreement, within 30 days of the filing of the petition when the child has been in placement 15 of the last 22 months, or within 15 days of a motion to terminate jurisdiction and to dismiss an order for foster care under chapter 260C, as provided in section 260D.09, paragraph (b).

(g) At the permanency review hearing, the court shall:

(1) inquire of the parent if the parent has reviewed the "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment," whether the petition is accurate, and whether the parent agrees to the continued voluntary foster care arrangement as being in the child's best interests;

(2) inquire of the parent if the parent is satisfied with the agency's reasonable efforts to finalize the permanent plan for the child, including whether there are services available and accessible to the parent that might allow the child to safely be with the child's family;

(3) inquire of the parent if the parent consents to the court entering an order that:

(i) approves the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing future planning for the safety, health, and best interests of the child; and

(ii) approves the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests; and

(4) inquire of the child's guardian ad litem and any other party whether the guardian or the party agrees that:

(i) the court should approve the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing and future planning for the safety, health, and best interests of the child; and

(ii) the court should approve of the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests.

(h) At a permanency review hearing under this section, the court may take the following actions based on the contents of the sworn petition and the consent of the parent:

(1) approve the agency's compelling reasons that the voluntary foster care arrangement is in the best interests of the child; and

(2) find that the agency has made reasonable efforts to finalize the permanent plan for the child.

(i) A child, age 12 or older, may object to the agency's request that the court approve its compelling reasons for the continued voluntary arrangement and may be heard on the reasons for the objection. Notwithstanding the child's objection, the court may approve the agency's compelling reasons and the voluntary arrangement.

(j) If the court does not approve the voluntary arrangement after hearing from the child or the child's guardian ad litem, the court shall dismiss the petition. In this case, either:

(1) the child must be returned to the care of the parent; or

(2) the agency must file a petition under section 260C.141, asking for appropriate relief under sections 260C.301 or 260C.503 to 260C.521.

(k) When the court approves the agency's compelling reasons for the child to continue in voluntary foster care for treatment, and finds that the agency has made reasonable efforts to finalize a permanent plan for the child, the court shall approve the continued voluntary foster care arrangement, and continue the matter under the court's jurisdiction for the purposes of reviewing the child's placement every 12 months while the child is in foster care.

(l) A finding that the court approves the continued voluntary placement means the agency has continued legal authority to place the child while a voluntary placement agreement remains in effect. The parent or the agency may terminate a voluntary agreement as provided in section 260D.10. Termination of a voluntary foster care placement of an Indian child is governed by section 260.765, subdivision 4.

Sec. 87. Minnesota Statutes 2024, section 260E.11, subdivision 3, is amended to read:

Subd. 3. **Report to medical examiner or coroner; notification to local agency and law enforcement; report ombudsman.** (a) A person mandated to report maltreatment who knows or has reason to believe a child has died as a result of maltreatment shall report that information to the appropriate medical examiner or coroner instead of the local welfare agency, police department, or county sheriff.

(b) The medical examiner or coroner shall notify the local welfare agency, police department, or county sheriff in instances in which the medical examiner or coroner believes that the child has died as a result of maltreatment. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff and the local welfare agency.

(c) If the child was receiving services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ from an agency, facility, or program as defined in section 245.91, the medical examiner or coroner shall also notify and report findings to the ombudsman established under sections 245.91 to 245.97.

Sec. 88. Minnesota Statutes 2024, section 295.50, subdivision 9b, is amended to read:

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

(1) bed and board;

(2) nursing services and other related services;

(3) use of hospitals, surgical centers, or health care provider facilities;

(4) medical social services;

(5) drugs, biologicals, supplies, appliances, and equipment;

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

(8) items and services furnished to ambulatory patients not requiring emergency care; and

(9) emergency services.

(b) "Patient services" does not include:

(1) services provided to nursing homes licensed under chapter 144A;

(2) examinations for purposes of utilization reviews, insurance claims or eligibility, litigation, and employment, including reviews of medical records for those purposes;

(3) services provided to and by community residential mental health facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by residential treatment programs for children with ~~severe emotional disturbance~~ a serious mental illness licensed or certified under chapter 245A;

(4) services provided under the following programs: day treatment services as defined in section 245.462, subdivision 8; assertive community treatment as described in section 256B.0622; adult rehabilitative mental health services as described in section 256B.0623; crisis response services as described in section 256B.0624; and children's therapeutic services and supports as described in section 256B.0943;

(5) services provided to and by community mental health centers as defined in section 245.62, subdivision 2;

(6) services provided to and by assisted living programs and congregate housing programs;

(7) hospice care services;

(8) home and community-based waivered services under chapter 256S and sections 256B.49 and 256B.501;

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

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

ARTICLE 11

ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES RECODIFICATION

Section 1. Minnesota Statutes 2024, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, assertive community treatment when the services are provided by an entity certified under and meeting the standards in this section.

~~(b) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.~~

~~(c)~~ (b) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Sec. 2. Minnesota Statutes 2024, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. **Medical assistance payment for assertive community treatment ~~and intensive residential treatment~~ services.** (a) Payment for ~~intensive residential treatment services and~~ assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph ~~(d)~~ (c), payment will not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

~~(c) Payment must not be made based solely on a court order to participate in intensive residential treatment services. If a client has a court order to participate in the program or to obtain assessment for treatment and follow treatment recommendations, payment under this section must only be provided if the client is eligible for the service and the service is determined to be medically necessary.~~

~~(d)~~ (c) The commissioner shall determine ~~one rate for each provider that will bill medical assistance for residential services under this section and~~ one rate for each assertive community treatment provider under this section. If a single entity provides both ~~services~~ intensive

residential treatment services under section 256B.0632 and assertive community treatment under this section, one rate is established for the entity's intensive residential treatment services under section 256B.0632 and another rate for the entity's ~~nonresidential~~ assertive community treatment services under this section. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(i) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(iv) assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); and

(v) subject to federal approval, up to an additional five percent of the total rate may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(2) actual ~~cost is~~ costs are defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

(3) the number of service units;

(4) the degree to which clients will receive services other than services under this section or section 256B.0632; and

(5) the costs of other services that will be separately reimbursed.

~~(e)~~ (d) The rate for ~~intensive residential treatment services and~~ assertive community treatment must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

~~(f) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.~~

~~(g)~~ (e) When services under this section are provided by an assertive community treatment provider, case management functions must be an integral part of the team.

~~(h)~~ (f) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

~~(i)~~ (g) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph ~~(d)~~ (c). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph ~~(d)~~ (c).

~~(j)~~ (h) Effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment, adult residential crisis stabilization services, and intensive residential treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. This paragraph expires upon federal approval.

(i) Effective upon the expiration of paragraph (h), and effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

~~(k)~~ (j) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

~~(l)~~ (k) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Sec. 3. Minnesota Statutes 2024, section 256B.0622, subdivision 11, is amended to read:

Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly to ~~intensive residential treatment services providers and~~ assertive community treatment providers to maintain access to these services.

Sec. 4. Minnesota Statutes 2024, section 256B.0622, subdivision 12, is amended to read:

Subd. 12. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian tribes, or mental health service providers to establish additional assertive community treatment teams~~, intensive residential treatment services, or crisis residential services~~.

Sec. 5. **[256B.0632] INTENSIVE RESIDENTIAL TREATMENT SERVICES.**

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(b) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

Subd. 2. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and Tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Subd. 3. **Medical assistance payment for intensive residential treatment services.** (a) Payment for intensive residential treatment services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (d), payment will not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) Payment must not be made based solely on a court order to participate in intensive residential treatment services. If a client has a court order to participate in the program or to obtain assessment for treatment and follow treatment recommendations, payment under this section must only be provided if the client is eligible for the service and the service is determined to be medically necessary.

(d) The commissioner shall determine one rate for each provider that will bill medical assistance for intensive residential treatment services under this section. If a single entity provides both intensive residential treatment services under this section and assertive community treatment under section 256B.0622, one rate is established for the entity's intensive residential treatment services under this section and another rate for the entity's assertive community treatment services under section 256B.0622. A provider is not eligible

for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(i) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space; and

(iv) subject to federal approval, up to an additional five percent of the total rate may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(2) actual costs are defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

(3) the number of services units;

(4) the degree to which clients will receive services other than services under this section or section 256B.0622; and

(5) the costs of other services that will be separately reimbursed.

(e) The rate for intensive residential treatment services must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(f) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services

treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.

(g) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(h) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (d). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (d).

(i) Effective upon the expiration of section 256B.0622, subdivision 8, paragraph (h), and effective for rate years beginning on and after January 1, 2024, rates for intensive residential treatment services and adult residential crisis stabilization services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(j) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

(k) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Subd. 4. **Provider enrollment; rate setting for county-operated entities.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required.

Subd. 5. **Provider enrollment; rate setting for specialized program.** A county contract is not required for a provider proposing to serve a subpopulation of eligible clients under the following circumstances:

(1) the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities; and

(2) the subpopulation to be served is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

Subd. 6. **Sustainability grants.** The commissioner may disburse grant funds directly to intensive residential treatment services providers to maintain access to these services.

Subd. 7. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian Tribes, or mental health service providers to establish additional intensive residential treatment services and residential crisis services.

Sec. 6. **REPEALER.**

Minnesota Statutes 2024, section 256B.0622, subdivision 4, is repealed.

ARTICLE 12

ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES RECODIFICATION CONFORMING CHANGES

Section 1. Minnesota Statutes 2024, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and staff persons providing co-occurring substance use disorder treatment in adult mental health rehabilitative programs certified or licensed by the

Department of Human Services under section 245I.23, 256B.0622, ~~or~~ 256B.0623, or 256B.0632.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling, or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 2. Minnesota Statutes 2024, section 245.4662, subdivision 1, is amended to read:

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

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapters 246 and 246C.

(d) "Intensive residential treatment services" has the meaning given in section ~~256B.0622~~ 256B.0632.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Sec. 3. Minnesota Statutes 2024, section 245.4906, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that employs a mental health certified peer specialist qualified under section 245I.04, subdivision 10, and that provides services to individuals receiving assertive community treatment ~~or intensive residential treatment services~~ under section 256B.0622, intensive residential treatment services under section 256B.0632, adult rehabilitative mental health services under section 256B.0623, or crisis response services under section 256B.0624.

Sec. 4. Minnesota Statutes 2024, section 254B.04, subdivision 1a, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (9).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 142G;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0150;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.05, subdivision 4.

(i) Persons enrolled in MinnesotaCare are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section ~~256B.0622~~ 256B.0632.

Sec. 5. Minnesota Statutes 2024, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site whenever a client is present;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(d) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

(e) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section ~~256B.0622 or~~ 256B.0624 or 256B.0632 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

(f) A vendor that is not licensed as a residential treatment program must have a policy to address staffing coverage when a client may unexpectedly need to be present at the room and board site.

Sec. 6. Minnesota Statutes 2024, section 256.478, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual can demonstrate that current services are not capable of meeting individual

treatment and service needs that can be met in the community with support, and the individual meets at least one of the following criteria:

(1) the person meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care, residential-level care, or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota Forensic Mental Health Program, the Child and Adolescent Behavioral Health Hospital program, a psychiatric residential treatment facility under section 256B.0941, intensive residential treatment services under section ~~256B.0622~~ 256B.0632, children's residential services under section 245.4882, juvenile detention facility, county supervised building, or a hospital would be substantially delayed without additional resources available through the transitions to community initiative;

(3) the person (i) is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) expresses a desire to move; and (iii) has received approval from the commissioner; or

(4) the person can demonstrate that the person's needs are beyond the scope of current service designs and grant funding can support the inclusion of additional supports for the person to access appropriate treatment and services in the least restrictive environment.

Sec. 7. Minnesota Statutes 2024, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, ~~and~~ 256B.0624, and 256B.0632 and are provided by a mental health certified peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Sec. 8. Minnesota Statutes 2024, section 256B.0615, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1) intensive residential treatment services under section ~~256B.0622~~ 256B.0632; (2) adult rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization and mental health mobile crisis intervention services under section 256B.0624.

Sec. 9. Minnesota Statutes 2024, section 256B.82, is amended to read:

256B.82 PREPAID PLANS AND MENTAL HEALTH REHABILITATIVE SERVICES.

Medical assistance and MinnesotaCare prepaid health plans may include coverage for adult mental health rehabilitative services under section 256B.0623, intensive rehabilitative services under section ~~256B.0622~~ 256B.0632, and adult mental health crisis response services under section 256B.0624, beginning January 1, 2005.

By January 15, 2004, the commissioner shall report to the legislature how these services should be included in prepaid plans. The commissioner shall consult with mental health advocates, health plans, and counties in developing this report. The report recommendations must include a plan to ensure coordination of these services between health plans and counties, assure recipient access to essential community providers, and monitor the health plans' delivery of services through utilization review and quality standards.

Sec. 10. Minnesota Statutes 2024, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a setting authorized to receive housing support payments under chapter 256I.

(b) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician, advanced practice registered nurse, or physician assistant. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(c) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(e) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(f) A fee equal to the maximum monthly amount allowed by the Social Security Administration is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half of the maximum federal Supplemental Security Income payment amount for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as in need of housing assistance and are:

(i) relocating from an institution, a setting authorized to receive housing support under chapter 256I, or an adult mental health residential treatment program under section ~~256B.0622~~ 256B.0632;

(ii) eligible for personal care assistance under section 256B.0659; or

(iii) home and community-based waiver recipients living in their own home or rented or leased apartment.

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Housing assistance" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered in need of housing assistance for purposes of this paragraph.

ARTICLE 13
BACKGROUND STUDIES

Section 1. Minnesota Statutes 2024, section 245C.13, subdivision 2, is amended to read:

Subd. 2. **Activities pending completion of background study.** The subject of a background study may not perform any activity requiring a background study under paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

(a) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245C.17 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual

affiliated with a Title IV-E eligible children's residential facility or foster residence setting, the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

(2) a notice that a disqualification has been set aside under section 245C.23; or

(3) a notice that a variance has been granted related to the individual under section 245C.30.

(b) For a background study affiliated with a licensed child care center or certified license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must not be issued until the commissioner receives a qualifying result for the individual for the fingerprint-based national criminal history record check or the fingerprint-based criminal history information from the Bureau of Criminal Apprehension. The notice must require the individual to be under continuous direct supervision prior to completion of the remainder of the background study except as permitted in subdivision 3.

(c) Activities prohibited prior to receipt of notice under paragraph (a) include:

(1) being issued a license;

(2) living in the household where the licensed program will be provided;

(3) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision;

(4) having access to persons receiving services if the background study was completed under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2), (5), or (6), unless the subject is under continuous direct supervision;

(5) for licensed child care centers and certified license-exempt child care centers, providing direct contact services to persons served by the program;

(6) for children's residential facilities or foster residence settings, working in the facility or setting; or

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study of the personal care assistant under this chapter and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

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

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22.

EFFECTIVE DATE. This section is effective January 15, 2026.

Sec. 2. Minnesota Statutes 2024, section 245C.14, is amended by adding a subdivision to read:

Subd. 4c. **Two-year disqualification.** An individual is disqualified under section 245C.14, subdivision 6, if less than two years has passed since a determination that the individual violated section 142A.12, 245.095, or 256B.064.

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

Sec. 3. Minnesota Statutes 2024, section 245C.14, is amended by adding a subdivision to read:

Subd. 6. **Disqualification from owning, operating, or billing.** The commissioner shall disqualify an individual who is the subject of a background study from any position involving ownership, management, or control of a program or billing activities if a background study completed under this chapter shows a violation of section 142A.12, 245.095, or 256B.064.

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

ARTICLE 14
DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY

Section 1. Minnesota Statutes 2024, section 13.46, subdivision 3, is amended to read:

Subd. 3. **Investigative data.** (a) Data on persons, including data on vendors of services, licensees, and applicants that is collected, maintained, used, or disseminated by the welfare system in an investigation, authorized by statute, and relating to the enforcement of rules or law are confidential data on individuals pursuant to section 13.02, subdivision 3, or protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and shall not be disclosed except:

(1) pursuant to section 13.05;

(2) pursuant to statute or valid court order;

(3) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense;

(4) to an agent ~~of the welfare system~~ or ~~an~~ investigator acting on behalf of a county, state, or federal government, including a law enforcement officer or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding, unless the commissioner of human services or commissioner of children, youth, and families determines that disclosure may compromise a Department of Human Services or Department of Children, Youth, and Families ongoing investigation; or

(5) to provide notices required or permitted by statute.

The data referred to in this subdivision shall be classified as public data upon submission to an administrative law judge or court in an administrative or judicial proceeding. Inactive welfare investigative data shall be treated as provided in section 13.39, subdivision 3.

(b) Notwithstanding any other provision in law, the commissioner of human services shall provide all active and inactive investigative data, including the name of the reporter of alleged maltreatment under section 626.557 or chapter 260E, to the ombudsman for mental health and developmental disabilities upon the request of the ombudsman.

(c) Notwithstanding paragraph (a) and section 13.39, the existence of an investigation by the commissioner of human services of possible overpayments of public funds to a service provider or recipient or the reduction or withholding of payments may be disclosed if the commissioner determines that it will not compromise the investigation.

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

Sec. 2. Minnesota Statutes 2024, section 245.095, subdivision 5, is amended to read:

Subd. 5. **Withholding of payments.** (a) Except as otherwise provided by state or federal law, the commissioner may withhold payments to a provider, vendor, individual, associated individual, or associated entity in any program administered by the commissioner if the commissioner determines:

(1) there is a credible allegation of fraud for which an investigation is pending for a program administered by a Minnesota state or federal agency.~~,~~;

(2) the individual, the entity, or an associated individual or entity was convicted of a crime charged in state or federal court with an offense that involves fraud or theft against a program administered by the commissioner or another Minnesota state or federal agency. For purposes of this subdivision, "convicted" means a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from the judgment is pending, and includes a stay of adjudication, a court-ordered diversion program, or a plea of guilty or nolo contendere;

(3) the provider is operating after a Minnesota state or federal agency orders the suspension, revocation, or decertification of the provider's license;

(4) the provider, vendor, associated individual, or associated entity, including those receiving funds under any contract or registered program, has a background study disqualification under chapter 245C that has not been set aside and for which no variance has been issued, except for a disqualification under sections 245C.14, subdivision 5, and 245C.15, subdivision 4c; or

(5) by a preponderance of the evidence that the provider, vendor, individual, associated individual, or associated entity intentionally provided materially false information on the provider's billing forms.

(b) For purposes of this subdivision, "credible allegation of fraud" means an allegation that has been verified by the commissioner from any source, including but not limited to:

(1) fraud hotline complaints;

(2) claims data mining;

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

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

(c) The commissioner must send notice of the withholding of payments within five days of taking such action. The notice must:

(1) state that payments are being withheld according to this subdivision;

(2) set forth the general allegations related to the withholding action, except the notice need not disclose specific information concerning an ongoing investigation;

(3) state that the withholding is for a temporary period and cite the circumstances under which the withholding will be terminated; and

(4) inform the provider, vendor, individual, associated individual, or associated entity of the right to submit written evidence to contest the withholding action for consideration by the commissioner.

(d) If the commissioner withholds payments under this subdivision, the provider, vendor, individual, associated individual, or associated entity has a right to request administrative reconsideration. A request for administrative reconsideration must be made in writing, state with specificity the reasons the payment withholding decision is in error, and include

documents to support the request. Within 60 days from receipt of the request, the commissioner shall judiciously review allegations, facts, evidence available to the commissioner, and information submitted by the provider, vendor, individual, associated individual, or associated entity to determine whether the payment withholding should remain in place.

(e) The commissioner shall stop withholding payments if the commissioner determines there is insufficient evidence of fraud by the provider, vendor, individual, associated individual, or associated entity or when legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice under subdivision 3 to the provider, vendor, individual, associated individual, or associated entity.

(f) The withholding of payments is a temporary action and is not subject to appeal under section 256.045 or chapter 14.

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

Sec. 3. Minnesota Statutes 2024, section 245.095, is amended by adding a subdivision to read:

Subd. 6. **Data practices.** The commissioner may exchange information, including claims data, with state or federal agencies, professional boards, departments, or programs for the purpose of investigating or prosecuting a criminal, civil, or administrative proceeding related to suspected fraud or exclusion from any program administered by a state or federal agency.

Sec. 4. Minnesota Statutes 2024, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, organization, or government entity that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within 30 miles of the Minnesota border. An applicant who intends to buy or otherwise acquire a program or services licensed under this chapter that is owned by another license holder must apply for a license under this chapter and comply with the application procedures in this section and section 245A.043.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or

departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the required information. If the applicant or a controlling individual is the subject of a pending administrative, civil, or criminal investigation, the application is not complete until the investigation has closed or the related legal proceedings are complete.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.043.

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

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

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

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

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

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

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

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

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

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

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

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

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

(3) the first, middle, and last name, and address for all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section

245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual;

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

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

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

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

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

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

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

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

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

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

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

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

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

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

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

Sec. 5. Minnesota Statutes 2024, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

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

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

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

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

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

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

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

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

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

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

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

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

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail, by personal service, or through the provider licensing and reporting hub. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. If the order is issued through the provider hub, the appeal must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

Sec. 6. Minnesota Statutes 2024, section 245A.07, subdivision 2, is amended to read:

Subd. 2. **Temporary immediate suspension.** (a) The commissioner shall act immediately to temporarily suspend a license issued under this chapter if:

(1) the license holder's or controlling individual's actions or failure to comply with applicable law or rule, or the actions of other individuals or conditions in the program, pose an imminent risk of harm to the health, safety, or rights of persons served by the program;

(2) while the program continues to operate pending an appeal of an order of revocation, the commissioner identifies one or more subsequent violations of law or rule which may adversely affect the health or safety of persons served by the program; or

(3) the license holder or controlling individual is criminally charged in state or federal court with an offense that involves fraud or theft against a program administered by ~~the commissioner~~ a state or federal agency.

(b) No state funds shall be made available or be expended by any agency or department of state, county, or municipal government for use by a license holder regulated under this chapter while a license issued under this chapter is under immediate suspension. A notice stating the reasons for the immediate suspension and informing the license holder of the right to an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612, must be delivered by personal service to the address shown on the application

or the last known address of the license holder. The license holder may appeal an order immediately suspending a license. The appeal of an order immediately suspending a license must be made in writing by certified mail, personal service, or other means expressly set forth in the commissioner's order. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice that the license has been immediately suspended. If a request is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. A license holder and any controlling individual shall discontinue operation of the program upon receipt of the commissioner's order to immediately suspend the license.

(c) The commissioner may act immediately to temporarily suspend a license issued under this chapter if the license holder or controlling individual is the subject of a pending administrative, civil, or criminal investigation or subject to an administrative or civil action related to fraud against a program administered by a state or federal agency.

Sec. 7. Minnesota Statutes 2024, section 254B.06, is amended by adding a subdivision to read:

Subd. 5. **Prohibition of duplicative claim submission.** (a) For time-based claims, submissions must follow the guidelines in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System and the American Medical Association's Current Procedural Terminology to determine the appropriate units of time to report.

(b) More than half the duration of a time-based code must be spent performing the service to be eligible under this section. Any provision of service during the remaining balance of the unit of time is not eligible for any other claims submission and would be considered a duplicative claim submission.

(c) A provider may only round up to the next whole number of service units on a submitted claim when more than one and one-half times the defined value of the code has occurred and no additional time increment code exists.

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

Sec. 8. Minnesota Statutes 2024, section 256.983, subdivision 4, is amended to read:

Subd. 4. **Funding.** (a) County and Tribal agency reimbursement shall be made through the settlement provisions applicable to the Supplemental Nutrition Assistance Program (SNAP), MFIP, child care assistance programs, the medical assistance program, and other federal and state-funded programs.

(b) The commissioners will maintain program compliance if for any ~~three consecutive month period~~ quarter, a county or Tribal agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost-effectiveness standards developed by the commissioners. This result is contingent on the commissioners providing written notice, including an offer of technical assistance, within 30 days of the end of the ~~third or subsequent month~~ quarter of noncompliance. The county or Tribal agency shall be required to submit a corrective action plan to the commissioners within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month, or billing the county or Tribal agency for fraud prevention investigation (FPI) service provided by the commissioners, or reallocation of program grant funds, or investigative resources, or both, to other counties or Tribal agencies. The denial of funding shall apply to the general settlement received by the county or Tribal agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

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

Sec. 9. Minnesota Statutes 2024, section 256B.04, subdivision 21, is amended to read:

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

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

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

(2) each personal care assistance agency under this subdivision once every three years~~.~~;

and

(3) at the commissioner's discretion, any other Medicaid-only provider type the commissioner deems "high risk" under this subdivision.

(c) The commissioner shall conduct revalidation as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) serves primarily a pediatric population.

(j) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and

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

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

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

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

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able

to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

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

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

Sec. 10. Minnesota Statutes 2024, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and email address;

(2) proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid 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;

(3) proof of fidelity bond coverage in the amount of $20,000 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business location where personal care assistance services are provided;

(5) proof of liability insurance coverage identifying the business location where personal care assistance services are provided and naming the department as a certificate holder;

(6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if enhanced personal care assistance services are provided and submitted for an enhanced rate under subdivision 17a;

(10) documentation of the agency's marketing practices;

(11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for

employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved

in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

(d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability insurance required by this subdivision must be maintained continuously. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

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

Sec. 11. Minnesota Statutes 2024, section 256B.85, subdivision 12, is amended to read:

Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS agency-providers must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS agency-provider in a format determined by the commissioner, information and documentation that includes but is not limited to the following:

(1) the CFSS agency-provider's current contact information including address, telephone number, and email address;

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. 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;

(3) proof of fidelity bond coverage in the amount of $20,000 per provider location;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a copy of the CFSS agency-provider's organizational chart identifying the names and roles of all owners, managing employees, staff, board of directors, and additional documentation reporting any affiliations of the directors and owners to other service providers;

(7) proof that the CFSS agency-provider has written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety, including the process for notification and resolution of participant grievances, incident response, identification and prevention of communicable diseases, and employee misconduct;

(8) proof that the CFSS agency-provider has all of the following forms and documents:

(i) a copy of the CFSS agency-provider's time sheet; and

(ii) a copy of the participant's individual CFSS service delivery plan;

(9) a list of all training and classes that the CFSS agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS agency-provider and staff have successfully completed all the training required by this section;

(11) documentation of the agency-provider's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except 100 percent of the revenue generated by a medical assistance rate increase due to a collective bargaining agreement under section 179A.54 must be used for support worker wages and benefits. The revenue generated by the worker training and development services and the reasonable costs associated with the worker training and development services shall not be used in making this calculation; and

(14) documentation that the agency-provider does not burden participants' free exercise of their right to choose service providers by requiring CFSS support workers to sign an agreement not to work with any particular CFSS participant or for another CFSS agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if they are hired by another agency and they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

(d) Agency-providers shall submit all required documentation in this section within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

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

ARTICLE 15

DEPARTMENT OF HUMAN SERVICES OFFICE OF THE INSPECTOR GENERAL POLICY

Section 1. Minnesota Statutes 2024, section 142E.51, subdivision 5, is amended to read:

Subd. 5. **Administrative disqualification of child care providers caring for children receiving child care assistance.** (a) The department shall pursue an administrative disqualification, if the child care provider is accused of committing an intentional program violation, in lieu of a criminal action when it has not been pursued. Intentional program violations include intentionally making false or misleading statements; receiving or providing a kickback, as defined in subdivision 6, paragraph (b); intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under this chapter. Intent may be proven by demonstrating a pattern of conduct that violates program rules under this chapter.

(b) To initiate an administrative disqualification, the commissioner must send written notice using a signature-verified confirmed delivery method to the provider against whom the action is being taken. Unless otherwise specified under this chapter or Minnesota Rules, chapter 3400, the commissioner must send the written notice at least 15 calendar days before

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

(c) The provider may appeal an administrative disqualification by submitting a written request to the state agency. A provider's request must be received by the state agency no later than 30 days after the date the commissioner mails the notice.

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

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

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

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

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

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

(f) The hearing is subject to the requirements of section 142A.20. The human services judge may combine a fair hearing and administrative disqualification hearing into a single hearing if the factual issues arise out of the same or related circumstances and the provider receives prior notice that the hearings will be combined.

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

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

Sec. 2. Minnesota Statutes 2024, section 142E.51, subdivision 6, is amended to read:

Subd. 6. **Prohibited hiring ~~practice~~ practices.** (a) It is prohibited to hire a child care center employee when, as a condition of employment, the employee is required to have one or more children who are eligible for or receive child care assistance, if:

(1) the individual hiring the employee is, or is acting at the direction of or in cooperation with, a child care center provider, center owner, director, manager, license holder, or other controlling individual; and

(2) the individual hiring the employee knows or has reason to know the purpose in hiring the employee is to obtain child care assistance program funds.

(b) Program applicants, participants, and providers are prohibited from receiving or providing a kickback or payment in exchange for obtaining or attempting to obtain child care assistance benefits for their own financial gain. This paragraph does not apply to:

(1) marketing or promotional offerings that directly benefit an applicant or recipient's child or dependent for whom the child care provider is providing child care services; or

(2) child care provider discounts, scholarships, or other financial assistance allowed under section 142E.17, subdivision 7.

(c) An attempt to buy or sell access to a family's child care subsidy benefits to an unauthorized person by an applicant, a participant, or a provider is a kickback, an intentional program violation under subdivision 5, and wrongfully obtaining assistance under section 256.98.

Sec. 3. Minnesota Statutes 2024, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, organization, or government entity that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within 30 miles of the Minnesota border. An applicant who intends to buy or otherwise acquire a program or services licensed under this chapter that is owned by another license holder must apply for a license under this chapter and comply with the application procedures in this section and section 245A.043.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the required information.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.043.

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

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

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

(e) The commissioner may limit communication during the application process to the authorized agent or the controlling individuals identified on the license application and for

whom a background study was initiated under chapter 245C. Upon implementation of the provider licensing and reporting hub, applicants and license holders must use the hub in the manner prescribed by the commissioner. The commissioner may require the applicant, except for child foster care, to demonstrate competence in the applicable licensing requirements by successfully completing a written examination. The commissioner may develop a prescribed written examination format.

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

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

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

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

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

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

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

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

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

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

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

(5) the documents that created the organization and that determine the organization's internal governance and the relations among the persons that own the organization, have an interest in the organization, or are members of the organization, in each case as provided

or authorized by the organization's governing statute, which may include a partnership agreement, bylaws, articles of organization, organizational chart, and operating agreement, or comparable documents as provided in the organization's governing statute; and

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

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

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

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

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

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

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

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

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

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

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

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

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

Sec. 4. Minnesota Statutes 2024, section 245A.04, subdivision 7, is amended to read:

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

(1) the name of the license holder;

(2) the address of the program;

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

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

(e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license affiliated with a license holder or controlling individual that had a license revoked within the past five years if the commissioner determines that (1) the license holder or controlling individual is operating the program in substantial compliance with applicable laws and rules and (2) the program's continued operation is in the best interests of the community being served.

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

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

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

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

(j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder

is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

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

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

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

Sec. 5. Minnesota Statutes 2024, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies that have been designated by the commissioner to perform licensing functions and activities under section 245A.04; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of child foster residence setting and community residential setting;

(2) until the responsibility for family child foster care transfers to the commissioner of children, youth, and families under Laws 2023, chapter 70, article 12, section 30, dual licensure of family child foster care and family adult foster care;

(3) until the responsibility for family child care transfers to the commissioner of children, youth, and families under Laws 2023, chapter 70, article 12, section 30, dual licensure of family adult foster care and family child care;

(4) adult foster care or community residential setting maximum capacity;

(5) adult foster care or community residential setting minimum age requirement;

(6) child foster care maximum age requirement;

(7) variances regarding disqualified individuals;

(8) the required presence of a caregiver in the adult foster care residence during normal sleeping hours;

(9) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder; and

(10) variances to section 142B.46 for the use of a cradleboard for a cultural accommodation.

(b) Once the respective responsibilities transfer from the commissioner of human services to the commissioner of children, youth, and families, under Laws 2023, chapter 70, article 12, section 30, the commissioners of human services and children, youth, and families must both approve a variance for dual licensure of family child foster care and family adult foster care or family adult foster care and family child care. Variances under this paragraph are excluded from the delegation of variance authority and may be issued only by both commissioners.

~~(c) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.~~

~~(d) A~~ (c) An adult foster care, family adult day services, child foster residence setting, or community residential services license issued under this section may be issued for up to two years until implementation of the provider licensing and reporting hub. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

~~(e)~~ (d) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

~~(f)~~ (e) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county agencies.

Sec. 6. Minnesota Statutes 2024, section 245A.242, subdivision 2, is amended to read:

Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency treatment of opioid overdose and must have a written standing order protocol by a physician who is licensed under chapter 147, advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of opiate antagonists on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both, before the staff has direct contact, as defined in section 245C.02, subdivision 11, with a person served by the program.

(b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

(1) emergency opiate antagonist medications are not required to be stored in a locked area and staff and adult clients may carry this medication on them and store it in an unlocked location;

(2) staff persons who only administer emergency opiate antagonist medications only require the training required by paragraph (a), which any knowledgeable trainer may provide. The trainer is not required to be a registered nurse or part of an accredited educational institution; and

(3) nonresidential substance use disorder treatment programs that do not administer client medications beyond emergency opiate antagonist medications are not required to have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and

must instead describe the program's procedures for administering opiate antagonist medications in the license holder's description of health care services under section 245G.08, subdivision 1.

Sec. 7. Minnesota Statutes 2024, section 245C.05, is amended by adding a subdivision to read:

Subd. 9. **Electronic signature.** For documentation requiring a signature under this chapter, use of an electronic signature as defined under section 325L.02, paragraph (h), is allowed.

Sec. 8. Minnesota Statutes 2024, section 245C.08, subdivision 3, is amended to read:

Subd. 3. **Arrest and investigative information.** (a) For any background study completed under this section, if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the commissioners of children, youth, and families; health; and human services;

(3) a ~~county attorney~~ prosecutor;

~~(4) a county sheriff;~~

~~(5)~~ (4) a county agency;

~~(6)~~ (5) a ~~local chief of police~~ law enforcement agency;

~~(7)~~ (6) other states;

~~(8)~~ (7) the courts;

~~(9)~~ (8) the Federal Bureau of Investigation;

~~(10)~~ (9) the National Criminal Records Repository; and

~~(11)~~ (10) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the entity that initiated the background study.

(c) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the data obtained is private data and cannot be shared with private agencies or prospective employers of the background study subject.

(d) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the license holder or entity that submitted the study is not required to obtain a copy of the background study subject's disqualification letter under section 245C.17, subdivision 3.

Sec. 9. Minnesota Statutes 2024, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, financial management services organizations, community first services and supports organizations, unlicensed home and community-based organizations, and consumer-directed community supports organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies in the substance use disorder treatment field, and the individual is the subject of a subsequent background study for a different program or agency in the substance use disorder treatment field, the commissioner shall set aside the disqualification for the program or agency in the substance use disorder treatment field that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified in section 245C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

(d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 10. Minnesota Statutes 2024, section 245D.02, subdivision 4a, is amended to read:

Subd. 4a. **Community residential setting.** "Community residential setting" means a residential program ~~as identified in section 245A.11, subdivision 8,~~ where residential supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause (3), items (i) and (ii), are provided to adults, as defined in section 245A.02, subdivision 2, and the license holder is the owner, lessor, or tenant of the facility licensed according to this chapter, and the license holder does not reside in the facility.

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

Sec. 11. Minnesota Statutes 2024, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,

the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 142G, 256B, 256D, 256I, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or food benefits produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care~~, or~~ by ~~furnishing or concurring in~~ receiving or providing any prohibited payment, as defined in section 609.542, subdivision 2, including a kickback, or by submitting or aiding or abetting the submission of a willfully false claim for child care assistance.

(b) The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 12. Minnesota Statutes 2024, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients of public assistance for which payment is made from medical assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the individual or entity is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services

provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; (8) soliciting or receiving any remuneration as defined in section 609.542, subdivision 3, or United States Code, title 42, section 1320a-7b(b)(1), and a criminal conviction is not required; (9) paying or offering to pay any remuneration as defined in section 609.542, subdivision 2, or United States Code, title 42, section 1320a-7b(b)(2), and a criminal conviction is not required; and ~~(8)~~ (10) any reason for which an individual or entity could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

Sec. 13. Minnesota Statutes 2024, section 256B.12, is amended to read:

256B.12 LEGAL REPRESENTATION.

The attorney general or the appropriate county attorney appearing at the direction of the attorney general shall be the attorney for the state agency, and the county attorney of the appropriate county shall be the attorney for the ~~local~~ agency in all matters pertaining hereto. To prosecute under this chapter or sections 609.466 ~~and~~, 609.52, subdivision 2~~,~~; and 609.542 or to recover payments wrongfully made under this chapter, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general may institute a criminal or civil action.

Sec. 14. **[609.542] HUMAN SERVICES PROGRAMS CRIMES.**

Subdivision 1. **Definition.** For purposes of this section, "federal health care program" has the meaning given in United States Code, title 42, section 1320a-7b(f).

Subd. 2. **Prohibited payments made relating to human services programs.** A person is guilty of a crime and may be sentenced as provided in subdivision 5 if the person intentionally offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, to another person:

(1) to induce that person to apply for, receive, or induce another person to apply for or receive an item or service for which payment may be made in whole or in part under a federal health care program, state behavioral health program under section 254B.04, or family program under chapter 142E; or

(2) in return for purchasing, leasing, ordering, or arranging for or inducing the purchasing, leasing, or ordering of any good, facility, service, or item for which payment may be made in whole or in part, or which is administered in whole or in part under a federal health care program, state behavioral health program under section 254B.04, or family program under chapter 142E.

Subd. 3. **Receipt of prohibited payments relating to human services programs.** A person is guilty of a crime and may be sentenced as provided in subdivision 5 if the person intentionally solicits or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind:

(1) in return for applying for or receiving a human services benefit, service, or grant for which payment may be made in whole or in part under a federal health care program, state behavioral health program under section 254B.04, or family program under chapter 142E; or

(2) in return for purchasing, leasing, ordering, or arranging for or inducing the purchasing, leasing, or ordering of any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program, state behavioral health program under section 254B.04, or family program under chapter 142E.

Subd. 4. **Exemptions.** (a) This section does not apply to remuneration exempted under the Anti-Kickback Statute, United States Code, title 42, section 1320a-7b(b)(3), or payment made under a federal health care program which is exempt from liability by United States Code, title 42, section 1001.952.

(b) This section does not apply to:

(1) any amount paid by an employer to a bona fide employee for providing covered items or services under chapter 142E while acting in the course and scope of employment; or

(2) child care provider discounts, scholarships, or other financial assistance to families allowed under section 142E.17, subdivision 7.

Subd. 5. **Sentence.** (a) A person convicted under subdivision 2 or 3 may be sentenced pursuant to section 609.52, subdivision 3.

(b) For purposes of sentencing a violation of subdivision 2, "value" means the fair market value of the good, facility, service, or item that was obtained as a direct or indirect result of the prohibited payment.

(c) For purposes of sentencing a violation of subdivision 3, "value" means the amount of the prohibited payment solicited or received.

(d) As a matter of law, a claim for any good, facility, service, or item rendered or claimed to have been rendered in violation of this section is noncompensable and unenforceable at the time the claim is made.

Subd. 6. **Aggregation.** In a prosecution under this section, the value of the money, property, or benefit received or solicited by the defendant within a six-month period may be aggregated and the defendant charged accordingly in applying the provisions of subdivision 5.

Subd. 7. **False claims.** In addition to the penalties provided for in this section, a claim, as defined in section 15C.01, subdivision 2, that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of section 15C.02.

EFFECTIVE DATE. This section is effective August 1, 2025, and applies to crimes committed on or after that date.

Sec. 15. Laws 2023, chapter 70, article 7, section 34, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~for background studies requested on or after August 1, 2024~~ the day following final enactment.

Sec. 16. **MODIFICATION OF DEFINITIONS.**

For the purposes of implementing the provider licensing and reporting hub, the commissioner of human services may modify definitions in Minnesota Statutes, chapters 142B, 245A, 245D, 245F, 245G, and 245I, and Minnesota Rules, chapters 2960, 9502, 9520, 9530, 9543, 9555, and 9570. Definitions changed pursuant to this section do not affect the rights, responsibilities, or duties of the commissioner; the Department of Human Services; programs administered, licensed, certified, or funded by the commissioner; or the programs' employees or clients. This section expires August 31, 2028.

Sec. 17. **REPEALER.**

Minnesota Statutes 2024, section 245A.11, subdivision 8, is repealed.

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

ARTICLE 16
ECONOMIC SUPPORTS

Section 1. Minnesota Statutes 2024, section 142A.03, is amended by adding a subdivision to read:

Subd. 35. **Electronic benefits transfer; contracting and procurement.** Notwithstanding chapter 16C, the commissioner is exempt from the contract term limits for the issuance of public benefits through an electronic benefit transfer system and related services. These contracts may have up to an initial five-year term, with extensions not to exceed a ten-year total contract duration.

Sec. 2. **[142F.141] PREPARED MEALS FOOD RELIEF GRANTS.**

Subdivision 1. **Establishment** The commissioner of children, youth, and families must establish a prepared meals grant program to provide hunger relief to Minnesotans experiencing food insecurity and who have difficulty preparing meals due to limited mobility, disability, or limited resources.

Subd. 2. **Eligible grantees.** (a) Eligible grantees are nonprofit organizations and federally recognized American Indian Tribes or Bands located in Minnesota, as defined in section 10.65, with a demonstrated history of providing and distributing prepared meals customized for the population that they serve, including tailoring meals to the cultural, religious, and dietary needs of the population served. Eligible grantees must prepare meals in a licensed commercial kitchen and distribute meals according to ServSafe guidelines.

(b) An individual or nonprofit organization affiliated with Feeding Our Future is prohibited from receiving grant funds under this section.

Subd. 3. **Application.** Applicants for grant money under this section must apply to the commissioner on the forms and in the time and manner established by the commissioner.

Subd. 4. **Allowable uses of grant funds.** Eligible grantees must use grant money awarded under this section to fund a prepared meals program that primarily targets individuals 18 years of age or older and under 61 years of age, and their dependents experiencing food

insecurity. Grantees must not receive funding from other state and federal meal programs for activities funded under this section.

Subd. 5. **Duties of the commissioner.** (a) The commissioner must develop a process for determining eligible grantees under this section.

(b) In granting money, the commissioner must prioritize applicants that:

(1) have demonstrated the ability to provide prepared meals to racially, ethnically, and geographically diverse populations at greater risk for food insecurity;

(2) work with external community partners to distribute meals targeting nontraditional meal sites reaching those most in need; and

(3) have a demonstrated history of sourcing at least 50 percent of the prepared meal ingredients from:

(i) Minnesota food producers and processors; or

(ii) food that is donated or would otherwise be waste.

(c) The commissioner must consider geographic distribution to ensure statewide coverage when awarding grants and minimize the number of grantees to simplify administrative burdens and costs.

Subd. 6. **Reporting.** (a) Grantees receiving money under this section must retain records documenting expenditure of the money and comply with any additional documentation requirements imposed by the commissioner.

(b) Grantees must report on the use of money received under this section to the commissioner. The commissioner must determine the timing and form required for the reports.

(c) If the commissioner determines that ineligible expenditures are made by grantees receiving money under this section, the ineligible amount must be repaid to the commissioner and deposited in the general fund.

Sec. 3. **[142F.16] REGIONAL FOOD BANK GRANTS.**

Subdivision 1. **Establishment.** The commissioner of children, youth, and families must establish regional food bank grants to increase the availability of food to individuals and families in need.

Subd. 2. **Distribution of appropriation.** The commissioner must distribute funds appropriated under this section to regional food banks and federally recognized American

Indian Tribes or Bands in Minnesota, as defined in section 10.65. The commissioner must distribute the funds under this section in accordance with the federal The Emergency Food Assistance Program (TEFAP) formula and guidelines of the United States Department of Agriculture. The commissioner may increase or decrease a qualifying recipient's proportionate amount if the commissioner determines the increase or decrease is necessary to meet community needs or demands for food in Minnesota. Food banks and American Indian Tribes or Bands must be in compliance with TEFAP regulations from the United States Department of Agriculture in order to receive funding under this section, as applicable.

Subd. 3. **Allowable uses of funds.** (a) Grant funds distributed to regional food banks under this section must be used to purchase, transport, and coordinate the distribution of food to TEFAP providers.

(b) Grant funds distributed to American Indian Tribes or Bands under this section must be used to purchase, transport, and coordinate the distribution of food to individuals and families in need.

(c) Grant funds distributed under this section may also be used to purchase personal hygiene products, including but not limited to diapers and toilet paper.

Subd. 4. **Reporting.** (a) Food banks and American Indian Tribes or Bands receiving grant funds under this section must retain records documenting expenditure of the grant funds and comply with any additional documentation requirements imposed by the commissioner.

(b) Food banks and American Indian Tribes or Bands must report on the use of grant funds received under this section to the commissioner. The commissioner must determine the timing and form required for the reports.

(c) If the commissioner determines that ineligible expenditures are made by food banks or American Indian Tribes or Bands receiving grant funds under this section, the ineligible amount must be repaid to the commissioner and deposited in the general fund.

Sec. 4. **FAMILY SUPPORTIVE HOUSING GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services must establish a family supportive housing grant program to award competitive grants to eligible applicants operating supportive housing for families.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Family" means a nontemporary household unit that includes at least one child and one parent or legal guardian.

(c) "Family permanent supportive housing" means housing that:

(1) is not time limited;

(2) is affordable for those at or below 30 percent of the area median income;

(3) offers specialized support services to residents tailored to the needs of children and families; and

(4) is available to families with multiple barriers to obtaining and maintaining housing, including but not limited to those who are homeless or at risk of homelessness; those with mental illness, substance use disorders, and other disabilities; and those referred by child protection services.

(d) "Resident" means a resident of family permanent supportive housing.

Subd. 3. **Eligibility.** To be eligible for a grant under this section, an applicant must be currently operating family supportive housing and be a nonprofit organization or Tribal government.

Subd. 4. **Application and administration.** (a) When applying to the commissioner for a grant under this section, each applicant must include the number of families they estimate to serve.

(b) Within available appropriations, the commissioner must award grant money to eligible grantees based on the estimated number of families served. The commissioner must use best efforts to ensure that 60 percent of the families served are within the seven-county metropolitan area and 40 percent of the families served are outside the seven-county metropolitan area. The commissioner must use best efforts to ensure that ten percent of the overall families served are members of Minnesota's Tribal Nations.

(c) By June 30, 2026, each grantee must provide a report to the commissioner on how many families the grantee served and what services the grantee provided.

Subd. 5. **Eligible uses of grant money.** An eligible applicant that receives grant money under this section must use the money for the services described in subdivision 6.

Subd. 6. **Specialized family support services.** Specialized family support services are nonmandatory, trauma-informed, and culturally appropriate services designed to help family residents maintain secure, dignified housing and provide a safe, stable environment for children. Services provided may include but are not limited to:

(1) age-appropriate child-centric services for education and enrichment;

(2) stabilization services such as:

(i) educational assessment and referrals to educational programs;

(ii) career planning, work skills training, job placement, and employment retention;

(iii) budgeting and money management;

(iv) referral for counseling regarding violence and sexual exploitation;

(v) referral for medical or psychiatric services or substance use disorder treatment;

(vi) parenting skills training;

(vii) self-sufficiency support services or life skills training, including tenant education and support to sustain housing; and

(viii) aftercare and follow-up services; and

(3) 24-hour-a-day, seven-day-a-week on-site staffing, including but not limited to front desk and security.

ARTICLE 17
CHILD PROTECTION AND WELFARE

Section 1. Minnesota Statutes 2024, section 142A.03, subdivision 2, is amended to read:

Subd. 2. **Duties of the commissioner.** (a) The commissioner may apply for and accept on behalf of the state any grants, bequests, gifts, or contributions for the purpose of carrying out the duties and responsibilities of the commissioner. Any money received under this paragraph is appropriated and dedicated for the purpose for which the money is granted. The commissioner must biennially report to the chairs and ranking minority members of relevant legislative committees and divisions by January 15 of each even-numbered year a list of all grants and gifts received under this subdivision.

(b) Pursuant to law, the commissioner may apply for and receive money made available from federal sources for the purpose of carrying out the duties and responsibilities of the commissioner.

(c) The commissioner may make contracts with and grants to Tribal Nations, public and private agencies, for-profit and nonprofit organizations, and individuals using appropriated money.

(d) The commissioner must develop program objectives and performance measures for evaluating progress toward achieving the objectives. The commissioner must identify the objectives, performance measures, and current status of achieving the measures in a biennial report to the chairs and ranking minority members of relevant legislative committees and divisions. The report is due no later than January 15 each even-numbered year. The report must include, when possible, the following objectives:

(1) centering and including the lived experiences of children and youth, including those with disabilities and mental illness and their families, in all aspects of the department's work;

(2) increasing the effectiveness of the department's programs in addressing the needs of children and youth facing racial, economic, or geographic inequities;

(3) increasing coordination and reducing inefficiencies among the department's programs and the funding sources that support the programs;

(4) increasing the alignment and coordination of family access to child care and early learning programs and improving systems of support for early childhood and learning providers and services;

(5) improving the connection between the department's programs and the kindergarten through grade 12 and higher education systems; and

(6) minimizing and streamlining the effort required of youth and families to receive services to which the youth and families are entitled.

(e) The commissioner shall administer and supervise the forms of public assistance and other activities or services that are vested in the commissioner. Administration and supervision of activities or services includes but is not limited to assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising activities vested by law in the department, the commissioner has the authority to:

(1) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing the programs and activities administered by the commissioner;

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

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

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

(5) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 142A.10;

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

(7) enter into contractual agreements with federally recognized Indian Tribes with a reservation in Minnesota to the extent necessary for the Tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and Tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

The commissioner shall work in conjunction with the commissioner of human services to carry out the duties of this paragraph when necessary and feasible.

(f) The commissioner shall inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs and activities administered by the commissioner.

(g) The commissioner shall administer and supervise child welfare activities, including promoting the enforcement of laws preventing child maltreatment and protecting children with a disability and children who are in need of protection or services, licensing and supervising child care and child-placing agencies, and supervising the care of children in foster care. The commissioner shall coordinate with the commissioner of human services on activities impacting children overseen by the Department of Human Services, such as disability services, behavioral health, and substance use disorder treatment.

(h) The commissioner shall assist and cooperate with local, state, and federal departments, agencies, and institutions.

(i) The commissioner shall establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(j) The commissioner shall act as designated guardian of children pursuant to chapter 260C. For children under the guardianship of the commissioner or a Tribe in Minnesota recognized by the Secretary of the Interior whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota Tribal social services agency to provide adoption services. For children in out-of-home care whose interests would be best served by a transfer of permanent legal and physical custody to a relative under section 260C.515, subdivision 4, or equivalent in Tribal code, the commissioner may contract with a licensed child-placing agency or a Minnesota Tribal social services agency to provide permanency services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs or Tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, Tribal governing body, or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(k) The commissioner has the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public benefits. To carry out the experimental projects, the commissioner may waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver must provide alternative methods and procedures of administration and must not conflict with the basic purposes, coverage, or benefits provided by law. No project under this paragraph shall exceed four years. No order establishing an experimental project as authorized by this paragraph is effective until the following conditions have been met:

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

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

(l) The commissioner shall, according to federal requirements and in coordination with the commissioner of human services, establish procedures to be followed by local welfare

boards in creating citizen advisory committees, including procedures for selection of committee members.

(m) The commissioner shall allocate federal fiscal disallowances or sanctions that are based on quality control error rates for the aid to families with dependent children (AFDC) program formerly codified in sections 256.72 to 256.87 or the Supplemental Nutrition Assistance Program (SNAP) in the following manner:

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For AFDC, disallowances shall be shared by each county board in the same proportion as that county's expenditures to the total of all counties' expenditures for AFDC. For SNAP, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for SNAP benefits are to the total of all SNAP administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of SNAP benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due under this paragraph, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

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

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

(o) The commissioner has the authority to establish and enforce the following county reporting requirements:

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

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

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

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

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

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

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

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

(q) The commissioner is responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the programs administered by the department. The commissioner shall cooperate with the commissioner of education to enforce the requirements for program integrity and fraud prevention for investigation for child care assistance under chapter 142E.

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

(s) The commissioner shall develop recommended standards for child foster care homes that address the components of specialized therapeutic services to be provided by child foster care homes with those services.

(t) The commissioner shall authorize the method of payment to or from the department as part of the programs administered by the department. This authorization includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the programs administered by the department.

(u) In coordination with the commissioner of human services, the commissioner shall create and provide county and Tribal agencies with blank applications, affidavits, and other forms as necessary for public assistance programs.

(v) The commissioner shall cooperate with the federal government and its public welfare agencies in any reasonable manner as may be necessary to qualify for federal aid for temporary assistance for needy families and in conformity with Title I of Public Law 104-193,

the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and successor amendments, including making reports that contain information required by the federal Social Security Advisory Board and complying with any provisions the board may find necessary to assure the correctness and verification of the reports.

(w) On or before January 15 in each even-numbered year, the commissioner shall make a biennial report to the governor concerning the activities of the agency.

(x) The commissioner shall enter into agreements with other departments of the state as necessary to meet all requirements of the federal government.

(y) The commissioner may cooperate with other state agencies in establishing reciprocal agreements in instances where a child receiving Minnesota family investment program (MFIP) assistance or its out-of-state equivalent moves or contemplates moving into or out of the state, in order that the child may continue to receive MFIP or equivalent aid from the state moved from until the child has resided for one year in the state moved to.

(z) The commissioner shall provide appropriate technical assistance to county agencies to develop methods to have county financial workers remind and encourage recipients of aid to families with dependent children, the Minnesota family investment program, the Minnesota family investment plan, family general assistance, or SNAP benefits whose assistance unit includes at least one child under the age of five to have each young child immunized against childhood diseases. The commissioner must examine the feasibility of utilizing the capacity of a statewide computer system to assist county agency financial workers in performing this function at appropriate intervals.

(aa) The commissioner shall have the power and authority to accept on behalf of the state contributions and gifts for the use and benefit of children under the guardianship or custody of the commissioner. The commissioner may also receive and accept on behalf of such children money due and payable to them as old age and survivors insurance benefits, veterans benefits, pensions, or other such monetary benefits. Gifts, contributions, pensions, and benefits under this paragraph must be deposited in and disbursed from the social welfare fund provided for in sections 256.88 to 256.92.

(bb) The specific enumeration of powers and duties in this section must not be construed to be a limitation upon the general powers granted to the commissioner.

Sec. 2. Minnesota Statutes 2024, section 260.810, subdivision 1, is amended to read:

Subdivision 1. **Payments.** The commissioner shall make grant payments to each approved program in four quarterly installments a year. The commissioner may certify an advance

payment for the first quarter of the state fiscal year. Later payments must be made ~~upon receipt by the state of a quarterly report on finances and program activities~~ quarterly.

Sec. 3. Minnesota Statutes 2024, section 260.810, subdivision 2, is amended to read:

Subd. 2. ~~**Quarterly report**~~ **Reporting.** The commissioner shall ~~specify~~ engage Tribal and urban Indian organizations to establish requirements for reports and reporting timelines, including ~~quarterly~~ fiscal reports submitted to the commissioner at least annually, according to section 142A.03, subdivision 2, paragraph (o). Each ~~quarter~~ reporting period as agreed upon by the commissioner and grantee, an approved program receiving an Indian child welfare grant shall submit a report to the commissioner that includes:

(1) a detailed accounting of grant money expended during the preceding ~~quarter~~ reporting period, specifying expenditures by line item and year to date; and

(2) a description of Indian child welfare activities conducted during the preceding ~~quarter~~ reporting period, including the number of clients served and the type of services provided.

~~The quarterly~~ Reports must be submitted no later than 30 days after the ~~end of each quarter~~ agreed upon reporting timelines of the state fiscal year.

Sec. 4. Minnesota Statutes 2024, section 260.821, subdivision 2, is amended to read:

Subd. 2. **Special focus grants.** The amount available for grants established under section 260.785, subdivision 2, for child-placing agencies, Tribes, Indian organizations, and other social services organizations is one-fifth of the total annual appropriation for Indian child welfare grants. ~~The maximum award under this subdivision is $100,000 a year for programs approved by the commissioner.~~

Sec. 5. **DIRECTION TO COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES; CHILD WELFARE FISCAL ANALYSIS.**

Subdivision 1. **Child welfare fiscal analysis.** The commissioner of children, youth, and families must contract with a third-party consultant selected according to subdivision 2 to conduct a fiscal analysis to identify and make recommendations on how to best utilize all available child welfare funding streams and federal resources for supporting children, families, and county and Tribal child welfare service providers across Minnesota.

Subd. 2. **Fiscal analysis consultant selection.** The commissioner, with input from the Association of Minnesota Counties, the Minnesota Indian Affairs Council, community nonprofits, community providers, and other child welfare system stakeholders, must select

an independent third-party consultant to conduct the fiscal analysis required under this section. The consultant must have expertise in and experience with child welfare systems and conducting fiscal analyses.

Subd. 3. **Child welfare fiscal analysis requirements.** When conducting the child welfare fiscal analysis under this section, the third-party consultant must evaluate:

(1) financial systems in Minnesota's child welfare system and funding sources available to the child welfare system; and

(2) state, county, and Tribal access to and use of funding or reimbursements for expenses related to child welfare, including but not limited to legal representation, training, and prevention services, under federal Title IV-E and Title IV-B, the federal Child Abuse Prevention and Treatment Act, TANF, Medicaid, the federal Social Services Block Grant Program, and other federal funds.

Subd. 4. **Stakeholder engagement.** The third-party consultant conducting the fiscal analysis under this section must engage with community child welfare service providers; state, county, and Tribal social services agencies; and other individuals or organizations with expertise in child welfare services, as the consultant determines to be appropriate.

Subd. 5. **Report on fiscal analysis.** By June 30, 2027, the third-party consultant conducting the child welfare fiscal analysis under this section must submit a report to the commissioner of children, youth, and families and the chairs and ranking minority members of the legislative committees with jurisdiction over the child welfare system. The report must include the findings from the fiscal analysis required in this section and recommendations on:

(1) how to maximize the state's receipt and use of child welfare funding streams and federal resources; and

(2) legislative proposals for any statutory or funding changes necessary to maximize the state's receipt and use of child welfare funding streams and federal resources.

Subd. 6. **Tribal participation.** Each of Minnesota's 11 federally recognized Tribal Nations may participate in the fiscal analysis required under this section. Tribal Nations that choose to participate have sovereignty over data they choose to share with the consultant, or other individuals or entities, and may request that their data not be included in any public documents.

Sec. 6. **SCAN OF AND REPORT ON OUT-OF-SCHOOL AND YOUTH PROGRAMMING.**

(a) The commissioner of children, youth, and families must conduct a scan of out-of-school and youth programming for youth under 21 years of age. The scan may include a review of existing reports, targeted interviews, surveys, and other methodologies, as determined by the commissioner.

(b) When conducting the scan, the commissioner must collaborate with community organizations and programming providers who provide out-of-school and youth programming; parents, youth, and families who participate or have participated in out-of-school and youth programming; and other individuals with expertise in out-of-school and youth programming in order to:

(1) identify different avenues for gathering information; and

(2) collaborate in the outreach and facilitation of focused community engagement.

(c) By July 1, 2026, the commissioner must prepare and submit a final report to the chairs and ranking minority members of the legislative committees with jurisdiction over children, youth, and families. The commissioner may contract with consultants to help with the development of the report. The report must include:

(1) information on current federal, state, Tribal, county, and city out-of-school and youth programs;

(2) school districts that offer enrichment activities;

(3) information on availability and amount of funding sources, the costs to provide the out-of-school and youth programs, and the costs of the programs for families;

(4) any barriers and gaps for families to participate in the out-of-school and youth programming, as identified by findings from the scan under paragraph (a) and in discussions with community members and program providers;

(5) information on the populations participating in out-of-school and youth programming;

(6) differences in programming needs, opportunities, and accessibility between different demographics and different regions of Minnesota; and

(7) recommendations on policy and funding needs, including recommending potential partners for program delivery to expand access to quality out-of-school and youth programming.

(d) By July 1, 2026, the commissioner must present the final report to the chairs and ranking minority members of the legislative committees with jurisdiction over children, youth, and families.

ARTICLE 18
CHILD PROTECTION AND WELFARE POLICY

Section 1. Minnesota Statutes 2024, section 142B.01, subdivision 15, is amended to read:

Subd. 15. **Individual who is related.** "Individual who is related" means a spouse, a parent, a birth or adopted child or stepchild, a stepparent, a stepbrother, a stepsister, a niece, a nephew, an adoptive parent, a grandparent, a sibling, an aunt, an uncle, or a legal guardian. For purposes of family child foster care, individual who is related also includes an individual who, prior to the child's placement in the individual's home for foster care or adoption, is an important individual of the child or of the child's parent or custodian. Important individual means an individual with whom the child has resided or had significant contact or who has a significant relationship to the child or the child's parent or custodian.

Sec. 2. Minnesota Statutes 2024, section 142B.05, subdivision 3, is amended to read:

Subd. 3. **Foster care by an individual who is related to a child; license required.** (a) Notwithstanding subdivision 2, paragraph (a), clause (1), in order to provide foster care for a child, an individual who is related to the child, other than a parent, or legal guardian, must be licensed by the commissioner except as provided by section 142B.06.

(b) An individual who is related to the child may seek foster care licensure through the county agency or a private agency in the community designated or licensed by the commissioner. The county agency, depending on funding available, must provide information to all potential relative foster care providers about this choice, including information about available private agencies for foster care licensure.

(c) If an individual who is related to a child is seeking licensure to provide foster care for the child and the individual has a domestic partner but is not married to the domestic partner, only the individual related to the child must be licensed to provide foster care. The commissioner must conduct background studies on household members according to section 245C.03, subdivision 1.

Sec. 3. Minnesota Statutes 2024, section 142B.47, is amended to read:

142B.47 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT DEATH AND ABUSIVE HEAD TRAUMA FOR CHILD FOSTER CARE PROVIDERS.

(a) Licensed child foster care providers, except individuals related to the child who only care for a relative child, that care for infants or children through five years of age must document that before caregivers assist in the care of infants or children through five years of age, ~~they~~ the caregivers are instructed on the standards in section 142B.46 and receive training on reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. Licensed child foster care providers who are related to the child and who only care for a relative child must document completion of the training required under this section within 30 days after licensure. This section does not apply to emergency relative placement under section 142B.06. The training on reducing the risk of sudden unexpected infant death and abusive head trauma may be provided as:

(1) orientation training to child foster care providers who care for infants or children through five years of age under Minnesota Rules, part 2960.3070, subpart 1; or

(2) in-service training to child foster care providers who care for infants or children through five years of age under Minnesota Rules, part 2960.3070, subpart 2.

(b) Training required under this section must be at least one hour in length and must be completed at least once every five years. At a minimum, the training must address the risk factors related to sudden unexpected infant death and abusive head trauma, means of reducing the risk of sudden unexpected infant death and abusive head trauma, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death and abusive head trauma.

(c) Training for child foster care providers must be approved by the county or private licensing agency that is responsible for monitoring the child foster care provider under section 142B.30. The approved training fulfills, in part, training required under Minnesota Rules, part 2960.3070.

Sec. 4. Minnesota Statutes 2024, section 142B.51, subdivision 2, is amended to read:

Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs licensed by the Department of Human Services under chapter 245A or the Department of Children, Youth, and Families under this chapter and Minnesota Rules, chapter 2960, that serve a child or children under eight years of age must document training that fulfills the requirements in this subdivision.

(b) Before a license holder, staff person, or caregiver transports a child or children under age eight in a motor vehicle, the person transporting the child must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this section may be used to meet initial or ongoing training under Minnesota Rules, part 2960.3070, subparts 1 and 2.

(c) Training required under this section must be completed at orientation or initial training and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(d) Training under paragraph (c) must be provided by individuals who are certified and approved by the Office of Traffic Safety within the Department of Public Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(e) Notwithstanding paragraph (a), for an emergency relative placement under section 142B.06, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety check up. The child seat safety check up trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one-on-one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety check up must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the other requirements of this subdivision prior to placement of another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.

(f) Notwithstanding paragraph (b), a child foster care license holder who is an individual related to the child, and who only serves a relative child, must document completion of the training required under this section within 30 days after licensure.

Sec. 5. Minnesota Statutes 2024, section 142B.80, is amended to read:

142B.80 CHILD FOSTER CARE TRAINING REQUIREMENT; MENTAL HEALTH TRAINING; FETAL ALCOHOL SPECTRUM DISORDERS TRAINING.

Prior to a nonemergency placement of a child in a foster care home, the child foster care license holder and caregivers in foster family and treatment foster care settings must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches for dealing with a child's behaviors. At least one hour of the annual training requirement for the foster family license holder and caregivers must be on children's mental health issues and treatment. Except for providers and services under chapter 245D and child foster care license holders who are individuals related to the child who only serve a relative child who does not have fetal alcohol spectrum disorder, the annual training must also include at least one hour of training on fetal alcohol spectrum disorders, which must be counted toward the 12 hours of required in-service training per year. Short-term substitute caregivers are exempt from these requirements. Training curriculum shall be approved by the commissioner of children, youth, and families.

Sec. 6. **[142B.81] CHILD FOSTER CARE TRAINING; RELATIVE CAREGIVERS.**

Notwithstanding the required hours under Minnesota Rules, part 2960.3070, subpart 2, a child foster care license holder who is an individual related to the child must complete a minimum of six hours of in-service training per year in one or more of the areas in Minnesota Rules, part 2960.3070, subpart 2, or in other areas as agreed upon by the licensing agency and the foster parent. The relative child foster care license holder must consult with the licensing agency and complete training in areas that are most applicable to caring for the relative children in foster care in the home. This section does not apply to a child foster care license holder who is licensed to care for both a relative child and a nonrelative child.

Sec. 7. Minnesota Statutes 2024, section 245C.02, is amended by adding a subdivision to read:

Subd. 16b. **Relative.** "Relative" has the meaning given in section 260C.007, subdivision 27. For purposes of background studies affiliated with child foster care licensure, a person is a relative if the person was known to the child or the child's parent before the child is placed in foster care.

Sec. 8. Minnesota Statutes 2024, section 245C.15, subdivision 4a, is amended to read:

Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, regardless of how much time has passed, an individual is disqualified under section 245C.14 if the individual committed an act that resulted in a felony-level conviction for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); ~~609.221 (assault in the first degree);~~ 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245 (aggravated robbery); 609.247, subdivision 2 or 3 (carjacking in the first or second degree); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and promotion of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.3458 (sexual extortion); 609.352 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary in the first degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors).

(b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14, regardless of how much time has passed, if the individual:

(1) committed an action under paragraph (e) that resulted in death or involved sexual abuse, as defined in section 260E.03, subdivision 20;

(2) committed an act that resulted in a gross misdemeanor-level conviction for section 609.3451 (criminal sexual conduct in the fifth degree);

(3) committed an act against or involving a minor that resulted in a felony-level conviction for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree); or

(4) committed an act that resulted in a misdemeanor or gross misdemeanor-level conviction for section 617.293 (dissemination and display of harmful materials to minors).

(c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting~~,~~:

(1) an individual is disqualified under section 245C.14 if fewer than 20 years have passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to involuntarily terminate parental rights. An individual is disqualified under section 245C.14 if fewer than 20 years have passed since the termination of the individual's parental rights in any other state or country, where the conditions for the individual's termination of parental rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph (b); or

(2) when an individual is a relative of the child in foster care, an individual is disqualified under section 245C.14 if fewer than seven years have passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to involuntarily terminate parental rights. An individual is disqualified under section 245C.14 if fewer than seven years have passed since the termination of the individual's parental rights in any other state or country, where the conditions for the individual's termination of parental rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph (b).

(d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if fewer than five years have passed since a felony-level violation for sections: 152.021 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the

fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing controlled substances across state borders); 152.0262, subdivision 1, paragraph (b) (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn child); 609.221 (assault in the first degree); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery); 609.247, subdivision 4 (carjacking in the third degree); 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

(e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if fewer than five years have passed since:

(1) a felony-level violation for an act not against or involving a minor that constitutes: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree);

(2) a violation of an order for protection under section 518B.01, subdivision 14;

(3) a determination or disposition of the individual's failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment was recurring or serious;

(4) a determination or disposition of the individual's substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under chapter 260E or section 626.557 and meet the definition of serious maltreatment or recurring maltreatment;

(5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

(6) committing an act against or involving a minor that resulted in a misdemeanor-level violation of section 609.224, subdivision 1 (assault in the fifth degree).

(f) For purposes of this subdivision, the disqualification begins from:

(1) the date of the alleged violation, if the individual was not convicted;

(2) the date of conviction, if the individual was convicted of the violation but not committed to the custody of the commissioner of corrections; or

(3) the date of release from prison, if the individual was convicted of the violation and committed to the custody of the commissioner of corrections.

Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation of the individual's supervised release, the disqualification begins from the date of release from the subsequent incarceration.

(g) Notwithstanding paragraph (f), for purposes of paragraph (d), the disqualification begins from the date of the alleged violation when the individual is a relative of the child in foster care.

(h) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if fewer than five years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (d) and (e).

~~(h)~~ (i) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraphs (a) and (b), permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if fewer than five years have passed since an offense in any other

state or country, the elements of which are substantially similar to the elements of any offense listed in paragraphs (d) and (e).

Sec. 9. Minnesota Statutes 2024, section 260.65, is amended to read:

260.65 NONCUSTODIAL PARENTS; RELATIVE PLACEMENT.

(a) Prior to the removal of an African American or a disproportionately represented child from the child's home, the responsible social services agency must make active efforts to identify and locate the child's noncustodial or nonadjudicated parent and the child's relatives to notify the child's parent and relatives that the child is or will be placed in foster care~~,~~ and provide the child's parent and relatives with a list of legal resources. The notice to the child's noncustodial or nonadjudicated parent and relatives must also include the information required under section 260C.221, subdivision 2, paragraph (b). The responsible social services agency must maintain detailed records of the agency's efforts to notify parents and relatives under this section.

(b) Notwithstanding the provisions of section 260C.219, the responsible social services agency must assess an African American or a disproportionately represented child's noncustodial or nonadjudicated parent's ability to care for the child before placing the child in foster care. If a child's noncustodial or nonadjudicated parent is willing and able to provide daily care for the African American or disproportionately represented child temporarily or permanently, the court shall order ~~that~~ the child ~~be placed in~~ into the home of the noncustodial or nonadjudicated parent pursuant to section 260C.178 or 260C.201, subdivision 1. The responsible social services agency must make active efforts to assist a noncustodial or nonadjudicated parent with remedying any issues that may prevent the child from being ~~placed with the~~ ordered into the home of a noncustodial or nonadjudicated parent.

(c) The relative search, notice, engagement, and placement consideration requirements under section 260C.221 apply under this act.

Sec. 10. Minnesota Statutes 2024, section 260.66, subdivision 1, is amended to read:

Subdivision 1. **Emergency removal or placement permitted.** Nothing in this section shall be construed to prevent the emergency removal of an African American or a disproportionately represented ~~child's parent or custodian~~ child or the emergency placement of the child in a foster setting in order to prevent imminent physical damage or harm to the child.

Sec. 11. Minnesota Statutes 2024, section 260.691, subdivision 1, is amended to read:

Subdivision 1. **Establishment and duties.** (a) The African American Child and Family Well-Being Advisory Council is established for the Department of Children, Youth, and Families.

(b) The council shall consist of 31 members appointed by the commissioner and must include representatives with lived personal or professional experience within African American communities. Members may include but are not limited to youth who have exited the child welfare system; parents; legal custodians; relative and kinship caregivers or foster care providers; community service providers, advocates, and members; county and private social services agency case managers; representatives from faith-based institutions; academic professionals; a representative from the Council for Minnesotans of African Heritage; the Ombudsperson for African American Families; and other individuals with experience and knowledge of African American communities. Council members must be selected through an open appointments process under section 15.0597. The terms, compensation, and removal of council members are governed by section 15.059.

(c) The ~~African American Child Well-Being Advisory~~ council must:

(1) review annual reports related to African American children involved in the child welfare system. These reports may include but are not limited to the maltreatment, out-of-home placement, and permanency of African American children;

(2) assist with and make recommendations to the commissioner for developing strategies to reduce maltreatment determinations, prevent unnecessary out-of-home placement, promote culturally appropriate foster care and shelter or facility placement decisions and settings for African American children in need of out-of-home placement, ensure timely achievement of permanency, and improve child welfare outcomes for African American children and their families;

(3) review summary reports on targeted case reviews prepared by the commissioner to ensure that responsible social services agencies meet the needs of African American children and their families. Based on data collected from those reviews, the council shall assist the commissioner with developing strategies needed to improve any identified child welfare outcomes, including but not limited to maltreatment, out-of-home placement, and permanency for African American children;

(4) ~~assist the Cultural and Ethnic Communities Leadership Council with making~~ make recommendations to the commissioner and the legislature for public policy and statutory

changes that specifically consider the needs of African American children and their families involved in the child welfare system;

(5) advise the commissioner on stakeholder engagement strategies and actions that the commissioner and responsible social services agencies may take to improve child welfare outcomes for African American children and their families;

(6) assist the commissioner with developing strategies for public messaging and communication related to racial disproportionality and disparities in child welfare outcomes for African American children and their families;

(7) assist the commissioner with identifying and developing internal and external partnerships to support adequate access to services and resources for African American children and their families, including but not limited to housing assistance, employment assistance, food and nutrition support, health care, child care assistance, and educational support and training; and

(8) assist the commissioner with developing strategies to promote the development of a culturally diverse and representative child welfare workforce in Minnesota that includes professionals who are reflective of the community served and who have been directly impacted by lived experiences within the child welfare system. The council must also assist the commissioner with exploring strategies and partnerships to address education and training needs, hiring, recruitment, retention, and professional advancement practices.

Sec. 12. Minnesota Statutes 2024, section 260.692, is amended to read:

260.692 AFRICAN AMERICAN CHILD AND FAMILY WELL-BEING UNIT.

Subdivision 1. **Duties.** The African American Child and Family Well-Being Unit, currently established by the commissioner, must:

(1) assist with the development of African American cultural competency training and review child welfare curriculum in the Minnesota Child Welfare Training Academy to ensure that responsible social services agency staff and other child welfare professionals are appropriately prepared to engage with African American children and their families and to support family preservation and reunification;

(2) provide technical assistance, including on-site technical assistance, and case consultation to responsible social services agencies to assist agencies with implementing and complying with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act;

(3) monitor individual county and statewide disaggregated and nondisaggregated data to identify trends and patterns in child welfare outcomes, including but not limited to reporting, maltreatment, out-of-home placement, and permanency of African American children and develop strategies to address disproportionality and disparities in the child welfare system;

(4) develop and implement a system for conducting case reviews when the commissioner receives reports of noncompliance with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act or when requested by the parent or custodian of an African American child. Case reviews may include but are not limited to a review of placement prevention efforts, safety planning, case planning and service provision by the responsible social services agency, relative placement consideration, and permanency planning;

(5) establish and administer a request for proposals process for African American and disproportionately represented family preservation grants under section 260.693, monitor grant activities, and provide technical assistance to grantees;

(6) in coordination with the African American Child and Family Well-Being Advisory Council, coordinate services and create internal and external partnerships to support adequate access to services and resources for African American children and their families, including but not limited to housing assistance, employment assistance, food and nutrition support, health care, child care assistance, and educational support and training; and

(7) develop public messaging and communication to inform the public about racial disparities in child welfare outcomes, current efforts and strategies to reduce racial disparities, and resources available to African American children and their families involved in the child welfare system.

Subd. 2. **Case reviews.** (a) The African American Child and Family Well-Being Unit must conduct systemic case reviews to monitor targeted child welfare outcomes, including but not limited to maltreatment, out-of-home placement, and permanency of African American children.

(b) The reviews under this subdivision must be conducted using a random sampling of representative child welfare cases stratified for certain case related factors, including but not limited to case type, maltreatment type, if the case involves out-of-home placement, and other demographic variables. In conducting the reviews, unit staff may use court records and documents, information from the social services information system, and other available case file information to complete the case reviews.

(c) The frequency of the reviews and the number of cases, child welfare outcomes, and selected counties reviewed shall be determined by the unit in consultation with the African American Child and Family Well-Being Advisory Council, with consideration given to the availability of unit resources needed to conduct the reviews.

(d) The unit must monitor all case reviews and use the collective case review information and data to generate summary case review reports, ensure compliance with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act, and identify trends or patterns in child welfare outcomes for African American children.

(e) The unit must review information from members of the public received through the compliance and feedback portal, including policy and practice concerns related to individual child welfare cases. After assessing a case concern, the unit may determine if further necessary action should be taken, which may include coordinating case remediation with other relevant child welfare agencies in accordance with data privacy laws, including the African American Child and Family Well-Being Advisory Council, and offering case consultation and technical assistance to the responsible local social services agency as needed or requested by the agency.

Subd. 3. **Reports.** (a) The African American Child and Family Well-Being Unit must provide regular updates on unit activities, including summary reports of case reviews, to the African American Child and Family Well-Being Advisory Council, and must publish an annual census of African American children in out-of-home placements statewide. The annual census must include data on the types of placements, age and sex of the children, how long the children have been in out-of-home placements, and other relevant demographic information.

(b) The African American Child and Family Well-Being Unit shall gather summary data about the practice and policy inquiries and individual case concerns received through the compliance and feedback portal under subdivision 2, paragraph (e). The unit shall provide regular reports of the nonidentifying compliance and feedback portal summary data to the African American Child and Family Well-Being Advisory Council to identify child welfare trends and patterns to assist with developing policy and practice recommendations to support eliminating disparity and disproportionality for African American children.

Sec. 13. Minnesota Statutes 2024, section 260C.001, subdivision 2, is amended to read:

Subd. 2. **Juvenile protection proceedings.** (a) The paramount consideration in all juvenile protection proceedings is the health, safety, and best interests of the child. In proceedings involving an American Indian child, as defined in section 260.755, subdivision

8, the best interests of the child must be determined consistent with sections 260.751 to 260.835 and the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923.

(b) The purpose of the laws relating to juvenile protection proceedings is:

(1) to secure for each child under the jurisdiction of the court, the care and guidance, preferably in the child's own home, as will best serve the spiritual, emotional, mental, and physical welfare of the child;

(2) to provide judicial procedures that protect the welfare of the child;

(3) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, removing the child from the custody of parents only when the child's welfare or safety cannot be adequately safeguarded without removal;

(4) to ensure that when removal from the child's own family is necessary and in the child's best interests, the responsible social services agency has legal responsibility for the child removal either:

(i) pursuant to a voluntary placement agreement between the child's parent or guardian or the child, when the child is over age 18, and the responsible social services agency; or

(ii) by court order pursuant to section 260C.151, subdivision 6; 260C.178; 260C.201; 260C.325; or 260C.515;

(5) to ensure that, when placement is pursuant to court order, the court order removing the child or continuing the child in foster care contains an individualized determination that placement is in the best interests of the child that coincides with the actual removal of the child;

(6) to ensure that when the child is removed, the child's care and discipline is, as nearly as possible, equivalent to that which should have been given by the parents and is either in:

(i) the home of a noncustodial parent pursuant to section 260C.178 or 260C.201, subdivision 1, paragraph (a), clause (1);

(ii) the home of a relative pursuant to emergency placement by the responsible social services agency under chapter 245A; or

(iii) foster care licensed under chapter 245A; and

(7) to ensure appropriate permanency planning for children in foster care including:

(i) unless reunification is not required under section 260.012, developing a permanency plan for the child that includes a primary plan for reunification with the child's parent or guardian and a secondary plan for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner;

(ii) identifying, locating, and assessing both parents of the child as soon as possible and offering reunification services to both parents of the child as required under sections 260.012 and 260C.219;

(iii) inquiring about the child's heritage, including the child's Tribal lineage pursuant to section 260.761, and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10;

~~(iii)~~ (iv) identifying, locating, and notifying relatives of both parents of the child according to section 260C.221;

~~(iv)~~ (v) making a placement with a family that will commit to being the legally permanent home for the child in the event reunification cannot occur at the earliest possible time while at the same time actively supporting the reunification plan; and

~~(v)~~ (vi) returning the child home with supports and services, as soon as return is safe for the child, or when safe return cannot be timely achieved, moving to finalize another legally permanent home for the child.

Sec. 14. Minnesota Statutes 2024, section 260C.007, subdivision 19, is amended to read:

Subd. 19. **Habitual truant.** (a) "Habitual truant" means a child under the age of 17 years who is absent from attendance at school without lawful excuse for seven school days per school year if the child is in elementary school or for one or more class periods on seven school days per school year if the child is in middle school, junior high school, or high school or a child who is 17 years of age who is absent from attendance at school without lawful excuse for one or more class periods on seven school days per school year and who has not lawfully withdrawn from school under section 120A.22, subdivision 8.

(b) For the purposes of educational neglect under section 260C.163, subdivision 11, habitual truant includes a child under 12 years of age who has been absent from school for seven school days without lawful excuse where the presumption of educational neglect is rebutted based on a showing by clear and convincing evidence that the child's absence is not due to the failure of the child's parent, guardian, or custodian to comply with compulsory instruction laws.

Sec. 15. Minnesota Statutes 2024, section 260C.150, subdivision 3, is amended to read:

Subd. 3. **Identifying parents of child; diligent efforts; data.** (a) The responsible social services agency shall make diligent efforts to inquire about the child's heritage, including the child's Tribal lineage pursuant to section 260.761 and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, and to identify and locate both parents of any child who is the subject of proceedings under this chapter. Diligent efforts include:

(1) asking the custodial or known parent to identify any nonresident parent of the child and provide information that can be used to verify the nonresident parent's identity including the dates and locations of marriages and divorces; dates and locations of any legal proceedings regarding paternity; date and place of the child's birth; nonresident parent's full legal name; nonresident parent's date of birth, or if the nonresident parent's date of birth is unknown, an approximate age; the nonresident parent's Social Security number; the nonresident parent's whereabouts including last known whereabouts; and the whereabouts of relatives of the nonresident parent. For purposes of this subdivision, "nonresident parent" means a parent who does not reside in the same household as the child or did not reside in the same household as the child at the time the child was removed when the child is in foster care;

(2) obtaining information that will identify and locate the nonresident parent from the county and state of Minnesota child support enforcement information system;

(3) requesting a search of the Minnesota Fathers' Adoption Registry 30 days after the child's birth; and

(4) using any other reasonable means to identify and locate the nonresident parent.

(b) The agency may disclose data which is otherwise private under section 13.46 or chapter 260E in order to carry out its duties under this subdivision.

(c) Upon the filing of a petition alleging the child to be in need of protection or services, the responsible social services agency may contact a putative father who registered with the Minnesota Fathers' Adoption Registry more than 30 days after the child's birth. The social service agency may consider a putative father for the day-to-day care of the child under section 260C.219 if the putative father cooperates with genetic testing and there is a positive test result under section 257.62, subdivision 5. Nothing in this paragraph:

(1) relieves a putative father who registered with the Minnesota Fathers' Adoption Registry more than 30 days after the child's birth of the duty to cooperate with paternity establishment proceedings under section 260C.219;

(2) gives a putative father who registered with the Minnesota Fathers' Adoption Registry more than 30 days after the child's birth the right to notice under section 260C.151 unless the putative father is entitled to notice under sections 259.24 and 259.49, subdivision 1, paragraph (a) or (b), clauses (1) to (7); or

(3) establishes a right to assert an interest in the child in a termination of parental rights proceeding contrary to section 259.52, subdivision 6, unless the putative father is entitled to notice under sections 259.24 and 259.49, subdivision 1, paragraph (a) or (b), clauses (1) to (7).

Sec. 16. Minnesota Statutes 2024, section 260C.202, subdivision 2, is amended to read:

Subd. 2. **Court review for a child placed in foster care.** (a) If the court orders a child placed in foster care, the court shall review the out-of-home placement plan and the child's placement at least every 90 days as required in juvenile court rules to determine whether continued out-of-home placement is necessary and appropriate or whether the child should be returned home.

(b) This review is not required if the court has returned the child home, ordered the child permanently placed away from the parent under sections 260C.503 to 260C.521, or terminated rights under section 260C.301. Court review for a child permanently placed away from a parent, including where the child is under guardianship of the commissioner, is governed by section 260C.607.

(c) When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(d) No later than three months after the child's placement in foster care, the court shall review agency efforts to search for and notify relatives pursuant to section 260C.221, and order that the agency's efforts begin immediately, or continue, if the agency has failed to perform, or has not adequately performed, the duties under that section. The court must order the agency to continue to appropriately engage relatives who responded to the notice under section 260C.221 in placement and case planning decisions and to consider relatives for foster care placement consistent with section 260C.221. Notwithstanding a court's finding that the agency has made reasonable efforts to search for and notify relatives under section 260C.221, the court may order the agency to continue making reasonable efforts to search for, notify, engage, and consider relatives who came to the agency's attention after sending the initial notice under section 260C.221.

(e) The court shall review the out-of-home placement plan and may modify the plan as provided under section 260C.201, subdivisions 6 and 7.

(f) When the court transfers the custody of a child to a responsible social services agency resulting in foster care or protective supervision with a noncustodial parent under subdivision 1, the court shall notify the parents of the provisions of sections 260C.204 and 260C.503 to 260C.521, as required under juvenile court rules.

~~(g) When a child remains in or returns to foster care pursuant to section 260C.451 and the court has jurisdiction pursuant to section 260C.193, subdivision 6, paragraph (c), the court shall at least annually conduct the review required under section 260C.203.~~

Sec. 17. Minnesota Statutes 2024, section 260C.204, is amended to read:

260C.204 PERMANENCY PROGRESS REVIEW FOR CHILDREN IN FOSTER CARE FOR SIX MONTHS.

(a) When a child continues in placement out of the home of the parent or guardian from whom the child was removed, no later than six months after the child's placement the court shall conduct a permanency progress hearing to review:

(1) the progress of the case, the parent's progress on the case plan or out-of-home placement plan, whichever is applicable;

(2) the agency's reasonable, or in the case of an Indian child, active efforts for reunification and its provision of services;

(3) the agency's reasonable efforts to finalize the permanent plan for the child under section 260.012, paragraph (e), and to make a placement as required under section 260C.212, subdivision 2, in a home that will commit to being the legally permanent family for the child in the event the child cannot return home according to the timelines in this section; and

(4) in the case of an Indian child, active efforts to prevent the breakup of the Indian family and to make a placement according to the placement preferences under United States Code, title 25, chapter 21, section 1915.

(b) When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(c) The court shall ensure that notice of the hearing is sent to any relative who:

(1) responded to the agency's notice provided under section 260C.221, indicating an interest in participating in planning for the child or being a permanency resource for the child and who has kept the court apprised of the relative's address; or

(2) asked to be notified of court proceedings regarding the child as is permitted in section 260C.152, subdivision 5.

(d)(1) If the parent or guardian has maintained contact with the child and is complying with the court-ordered out-of-home placement plan, and if the child would benefit from reunification with the parent, the court may either:

(i) return the child home, if the conditions that led to the out-of-home placement have been sufficiently mitigated that it is safe and in the child's best interests to return home; or

(ii) continue the matter up to a total of six additional months. If the child has not returned home by the end of the additional six months, the court must conduct a hearing according to sections 260C.503 to 260C.521.

(2) If the court determines that the parent or guardian is not complying, is not making progress with or engaging with services in the out-of-home placement plan, or is not maintaining regular contact with the child as outlined in the visitation plan required as part of the out-of-home placement plan under section 260C.212, the court may order the responsible social services agency:

(i) to develop a plan for legally permanent placement of the child away from the parent;

(ii) to consider, identify, recruit, and support one or more permanency resources from the child's relatives and foster parent, consistent with clause (3) and section 260C.212, subdivision 2, paragraph (a), to be the legally permanent home in the event the child cannot be returned to the parent. Any relative or the child's foster parent may ask the court to order the agency to consider them for permanent placement of the child in the event the child cannot be returned to the parent. A relative or foster parent who wants to be considered under this item shall cooperate with the background study required under section 245C.08, if the individual has not already done so, and with the home study process required under chapter 142B for providing child foster care and for adoption under section 259.41. The home study referred to in this item shall be a single-home study in the form required by the commissioner of children, youth, and families or similar study required by the individual's state of residence when the subject of the study is not a resident of Minnesota. The court may order the responsible social services agency to make a referral under the Interstate Compact on the Placement of Children when necessary to obtain a home study for an

individual who wants to be considered for transfer of permanent legal and physical custody or adoption of the child; and

(iii) to file a petition to support an order for the legally permanent placement plan.

(3) Consistent with section 260C.223, subdivision 2, paragraph (b), the responsible social services agency must not define a foster family as the permanent home for a child until:

(i) inquiry and Tribal notice requirements under section 260.761, subdivisions 1 and 2, are satisfied;

(ii) inquiry about the child's heritage, including their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, has been completed; and

(iii) the court has determined that reasonable or active efforts toward completing the relative search requirements in section 260C.221 have been made.

(e) Following the review under this section:

(1) if the court has either returned the child home or continued the matter up to a total of six additional months, the agency shall continue to provide services to support the child's return home or to make reasonable efforts to achieve reunification of the child and the parent as ordered by the court under an approved case plan;

(2) if the court orders the agency to develop a plan for the transfer of permanent legal and physical custody of the child to a relative, a petition supporting the plan shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the pleadings; or

(3) if the court orders the agency to file a termination of parental rights, unless the county attorney can show cause why a termination of parental rights petition should not be filed, a petition for termination of parental rights shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the petition.

Sec. 18. Minnesota Statutes 2024, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** ~~(a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.~~

~~(b)~~ (a) An out-of-home placement plan means a written document individualized to the needs of the child and the child's parents or guardians that is prepared by the responsible

social services agency using a form developed by the commissioner. The plan must be completed jointly with the child's parents or guardians and in consultation with the child's guardian ad litem; the child's tribe, if the child is an Indian child; the child's foster parent or representative of the foster care facility; and, when appropriate, the child. When a child is age 14 or older, the child may include two other individuals on the team preparing the child's out-of-home placement plan. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards. The responsible social services agency may reject an individual selected by the child if the agency has good cause to believe that the individual would not act in the best interest of the child. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. For a child 18 years of age or older, the responsible social services agency shall involve the child and the child's parents as appropriate. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(b) Before an out-of-home placement plan is signed by the parent or parents or guardian of the child, the responsible social services agency must provide the parent or parents or guardian with a one- to two-page summary of the plan using a form developed by the commissioner. The out-of-home placement plan summary must clearly summarize the plan's contents under paragraph (d) and list the requirements and responsibilities for the parent or parents or guardian using plain language. The summary must be updated and provided to the parent or parents or guardian when the out-of-home placement plan is updated under subdivision 1a.

(c) An out-of-home placement plan summary shall be prepared within 30 days after any child is placed in foster care by court order or voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D. An out-of-home placement plan shall be prepared within 60 days after any child is placed in foster care by court order or a voluntary placement agreement between

the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.

~~(c)~~ (d) The out-of-home placement plan shall be explained by the responsible social services agency to all persons involved in the plan's implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the foster care home or facility selected, including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like setting available that is in close proximity to the home of the child's parents or guardians when the case plan goal is reunification; and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) a description of the services offered and provided to prevent removal of the child from the home;

~~(2)~~ (3) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents that necessitated removal of the child from home and the services offered and provided to support the changes the parent or parents must make for the child to safely return home~~;~~

~~(3) a description of the services offered and provided to prevent removal of the child from the home~~ and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 26b or 27, and siblings of the child if the siblings are not

placed together in foster care, and whether visitation is consistent with the best interest of the child, during the period the child is in foster care;

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize permanency through either:

(i) adoption as the permanency plan for the child through reasonable efforts to place the child for adoption pursuant to section 260C.605. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child and child-specific recruitment efforts such as a relative search, consideration of relatives for adoptive placement, and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b); or

~~(7) when a child cannot return to or be in the care of either parent, documentation of steps to finalize~~ (ii) the transfer of permanent legal and physical custody to a relative as the permanency plan for the child. This documentation must support the requirements of the kinship placement agreement under section 142A.605 and must include the reasonable efforts used to determine that it is not appropriate for the child to return home or be adopted, and reasons why permanent placement with a relative through a Northstar kinship assistance arrangement is in the child's best interest; how the child meets the eligibility requirements for Northstar kinship assistance payments; agency efforts to discuss adoption with the child's relative foster parent and reasons why the relative foster parent chose not to pursue adoption, if applicable; and agency efforts to discuss with the child's parent or parents the permanent transfer of permanent legal and physical custody or the reasons why these efforts were not made;

~~(8)~~ (7) efforts to ensure the child's educational stability while in foster care for a child who attained the minimum age for compulsory school attendance under state law and is enrolled full time in elementary or secondary school, or instructed in elementary or secondary education at home, or instructed in an independent study elementary or secondary program, or incapable of attending school on a full-time basis due to a medical condition that is documented and supported by regularly updated information in the child's case plan. Educational stability efforts include:

(i) efforts to ensure that the child remains in the same school in which the child was enrolled prior to placement or upon the child's move from one placement to another, including

efforts to work with the local education authorities to ensure the child's educational stability and attendance; or

(ii) if it is not in the child's best interest to remain in the same school that the child was enrolled in prior to placement or move from one placement to another, efforts to ensure immediate and appropriate enrollment for the child in a new school;

~~(9)~~ (8) the educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a statement about how the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement; and

(v) any other relevant educational information;

~~(10)~~ (9) the efforts by the responsible social services agency to ~~ensure~~ support the child's well-being by ensuring the oversight and continuity of health care services for the foster child and documenting their health record, including:

(i) the plan to schedule the child's initial health screens;

(ii) how the child's known medical problems and identified needs from the screens, including any known communicable diseases, as defined in section 144.4172, subdivision 2, shall be monitored and treated while the child is in foster care;

(iii) how the child's medical information shall be updated and shared, including the child's immunizations;

(iv) who is responsible to coordinate and respond to the child's health care needs, including the role of the parent, the agency, and the foster parent;

(v) who is responsible for oversight of the child's prescription medications;

(vi) how physicians or other appropriate medical and nonmedical professionals shall be consulted and involved in assessing the health and well-being of the child and determine the appropriate medical treatment for the child; ~~and~~

(vii) the responsibility to ensure that the child has access to medical care through either medical insurance or medical assistance; and

~~(11) the health records of the child including~~ (viii) information available regarding:

~~(i)~~ (A) the names and addresses of the child's health care and dental care providers;

~~(ii)~~ (B) a record of the child's immunizations;

~~(iii)~~ (C) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

~~(iv)~~ (D) the child's medications; and

~~(v)~~ (E) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

~~(12)~~ (10) an independent living plan for a child 14 years of age or older, developed in consultation with the child. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards in subdivision 14. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the responsible social services agency to ensure that the child annually receives, at no cost to the child, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills;

(vii) establishing and maintaining connections with the child's family and community; and

(viii) regular opportunities to engage in age-appropriate or developmentally appropriate activities typical for the child's age group, taking into consideration the capacities of the individual child;

~~(13)~~ (11) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes;

~~(14)~~ (12) for a child 14 years of age or older, a signed acknowledgment that describes the child's rights regarding education, health care, visitation, safety and protection from exploitation, and court participation; receipt of the documents identified in section 260C.452; and receipt of an annual credit report. The acknowledgment shall state that the rights were explained in an age-appropriate manner to the child; and

~~(15)~~ (13) for a child placed in a qualified residential treatment program, the plan must include the requirements in section 260C.708.

~~(d)~~ (e) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

~~(e) Before an out-of-home placement plan is signed by the parent or parents or guardian of the child, the responsible social services agency must provide the parent or parents or guardian with a one- to two-page summary of the plan using a form developed by the commissioner. The out-of-home placement plan summary must clearly summarize the plan's contents under paragraph (c) and list the requirements and responsibilities for the parent or parents or guardian using plain language. The summary must be updated and provided to the parent or parents or guardian when the out-of-home placement plan is updated under subdivision 1a.~~

(f) After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

(g) Upon the child's discharge from foster care, the responsible social services agency must provide the child's parent, adoptive parent, or permanent legal and physical custodian, and the child, if the child is 14 years of age or older, with a current copy of the child's health and education record. If a child meets the conditions in subdivision 15, paragraph (b), the agency must also provide the child with the child's social and medical history. The responsible social services agency may give a copy of the child's health and education record and social and medical history to a child who is younger than 14 years of age, if it is appropriate and if subdivision 15, paragraph (b), applies.

Sec. 19. Minnesota Statutes 2024, section 260C.212, subdivision 1a, is amended to read:

Subd. 1a. **Out-of-home placement plan update.** (a) Within 30 days of placing the child in foster care, the agency must complete the child's out-of-home placement plan summary and file it with the court. Within 60 days of placing the child in foster care, the agency must file the child's initial out-of-home placement plan with the court. After filing the child's ~~initial~~ out-of-home placement plan, the agency shall update and file the child's out-of-home placement plan with the court as follows:

(1) when the agency moves a child to a different foster care setting, the agency shall inform the court within 30 days of the child's placement change or court-ordered trial home visit. The agency must file the child's updated out-of-home placement plan summary and out-of-home placement plan with the court at the next required review hearing;

(2) when the agency places a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, or moves a child from one qualified residential treatment program to a different qualified residential treatment program, the agency must update the child's out-of-home placement plan within 60 days. To meet the requirements of section 260C.708, the agency must file the child's out-of-home placement plan along with the agency's report seeking the court's approval of the child's placement at a qualified residential treatment program under section 260C.71. After the court issues an order, the agency must update the child's out-of-home placement plan to document the court's approval or disapproval of the child's placement in a qualified residential treatment program;

(3) when the agency places a child with the child's parent in a licensed residential family-based substance use disorder treatment program under section 260C.190, the agency must identify the treatment program where the child will be placed in the child's out-of-home placement plan prior to the child's placement. The agency must file the child's out-of-home placement plan summary and out-of-home placement plan with the court at the next required review hearing; and

(4) under sections 260C.227 and 260C.521, the agency must update the child's out-of-home placement plan summary and out-of-home placement plan and file the child's out-of-home placement plan with the court.

(b) When none of the items in paragraph (a) apply, the agency must update the child's out-of-home placement plan summary and out-of-home placement plan no later than 180 days after the child's initial placement and every six months thereafter, consistent with section 260C.203, paragraph (a).

Sec. 20. Minnesota Statutes 2024, section 260C.221, subdivision 2, is amended to read:

Subd. 2. **Relative notice requirements.** (a) The agency may provide oral or written notice to a child's relatives. In the child's case record, the agency must document providing the required notice to each of the child's relatives. The responsible social services agency must notify relatives:

(1) of the need for a foster home for the child, the option to become a placement resource for the child, the order of placement that the agency will consider under section 260C.212, subdivision 2, paragraph (a), and the possibility of the need for a permanent placement for the child;

(2) of their responsibility to keep the responsible social services agency and the court informed of their current address in order to receive notice in the event that a permanent placement is sought for the child and to receive notice of the permanency progress review hearing under section 260C.204. A relative who fails to provide a current address to the responsible social services agency and the court forfeits the right to receive notice of the possibility of permanent placement and of the permanency progress review hearing under section 260C.204, until the relative provides a current address to the responsible social services agency and the court. A decision by a relative not to be identified as a potential permanent placement resource or participate in planning for the child shall not affect whether the relative is considered for placement of, or as a permanency resource for, the child with that relative at any time in the case, and shall not be the sole basis for the court to rule out the relative as the child's placement or permanency resource;

(3) that the relative may participate in the care and planning for the child, as specified in subdivision 3, including that the opportunity for such participation may be lost by failing to respond to the notice sent under this subdivision;

(4) of the family foster care licensing and adoption home study requirements, including:

(i) how to complete an application ~~and~~;

(ii) how to request a variance from licensing standards that do not present a safety or health risk to the child in the home under section 142B.10 ~~and~~;

(iii) supports that are available for relatives and children who reside in a family foster home, including how to access respite care, strategies for leveraging natural supports for the child and family, and ways to include resource or substitute caregivers in the child's case plan; and

(iv) the relative's choice between county or private agency and services provided by that agency under section 142B.30, depending on funding available;

(5) of the relatives' right to ask to be notified of any court proceedings regarding the child, to attend the hearings, and of a relative's right to be heard by the court as required under section 260C.152, subdivision 5;

(6) that regardless of the relative's response to the notice sent under this subdivision, the agency is required to establish permanency for a child, including planning for alternative permanency options if the agency's reunification efforts fail or are not required; ~~and~~

(7) that by responding to the notice, a relative may receive information about participating in a child's family and permanency team if the child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d; and

(8) information advising a relative on access to legal services and support.

(b) The responsible social services agency shall send the notice required under paragraph (a) to relatives who become known to the responsible social services agency, except for relatives that the agency does not contact due to safety reasons under subdivision 5, paragraph (b). The responsible social services agency shall continue to send notice to relatives notwithstanding a court's finding that the agency has made reasonable efforts to conduct a relative search.

(c) The responsible social services agency is not required to send the notice under paragraph (a) to a relative who becomes known to the agency after an adoption placement agreement has been fully executed under section 260C.613, subdivision 1. If the relative wishes to be considered for adoptive placement of the child, the agency shall inform the relative of the relative's ability to file a motion for an order for adoptive placement under section 260C.607, subdivision 6.

Sec. 21. Minnesota Statutes 2024, section 260C.223, subdivision 1, is amended to read:

Subdivision 1. **Program; goals.** (a) The commissioner of children, youth, and families shall establish a program for concurrent permanency planning for child protection services.

(b) Concurrent permanency planning involves a planning process for children who are placed out of the home of their parents pursuant to a court order, or who have been voluntarily placed out of the home by the parents for 60 days or more and who are not developmentally disabled or emotionally disabled under section 260C.212, subdivision 9. The responsible social services agency shall develop an alternative permanency plan while making reasonable

efforts for reunification of the child with the family, if required by section 260.012. The goals of concurrent permanency planning are to:

(1) achieve early permanency for children;

(2) decrease children's length of stay in foster care and reduce the number of moves children experience in foster care; and

(3) ~~develop a group of families~~ establish a foster parent for a child who will work towards reunification and also serve as a permanent ~~families~~ family for children.

Sec. 22. Minnesota Statutes 2024, section 260C.223, subdivision 2, is amended to read:

Subd. 2. **Development of guidelines and protocols.** (a) The commissioner shall establish guidelines and protocols for social services agencies involved in concurrent permanency planning, including criteria for conducting concurrent permanency planning based on relevant factors such as:

(1) age of the child and duration of out-of-home placement;

(2) prognosis for successful reunification with parents;

(3) availability of relatives and other concerned individuals to provide support or a permanent placement for the child; and

(4) special needs of the child and other factors affecting the child's best interests.

(b) In developing the guidelines and protocols, the commissioner shall consult with interest groups within the child protection system, including child protection workers, child protection advocates, county attorneys, law enforcement, community service organizations, the councils of color, and the ombudsperson for families.

(c) The responsible social services agency must not make a foster family the permanent home for a child until:

(1) inquiry and Tribal notice requirements under section 260.761, subdivisions 1 and 2, are satisfied;

(2) inquiry about the child's heritage, including their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, has been completed; and

(3) the court has determined that reasonable or active efforts toward completing the relative search requirements in section 260C.221 have been made.

Sec. 23. Minnesota Statutes 2024, section 260C.329, subdivision 8, is amended to read:

Subd. 8. **Hearing.** The court may grant the petition ordering the reestablishment of the legal parent and child relationship only if it finds by clear and convincing evidence that:

(1) reestablishment of the legal parent and child relationship is in the child's best interests;

(2) the child ~~has~~ is not ~~been~~ currently adopted;

(3) the child is not the subject of a written adoption placement agreement between the responsible social services agency and the prospective adoptive parent, as required under Minnesota Rules, part 9560.0060, subpart 2;

(4) at least 24 months have elapsed following a final order terminating parental rights and the child remains in foster care;

(5) the child desires to reside with the parent;

(6) the parent has corrected the conditions that led to an order terminating parental rights; and

(7) the parent is willing and has the capability to provide day-to-day care and maintain the health, safety, and welfare of the child.

Sec. 24. Minnesota Statutes 2024, section 260C.452, subdivision 4, is amended to read:

Subd. 4. **Administrative or court review of placements.** (a) When the youth is 14 years of age or older, the court, in consultation with the youth, shall review the youth's independent living plan according to section 260C.203, paragraph (d).

(b) The responsible social services agency shall file a copy of the notification of foster care benefits for a youth who is 18 years of age or older according to section 260C.451, subdivision 1, with the court. If the responsible social services agency does not file the notice by the time the youth is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) When a youth is 18 years of age or older, the court shall ensure that the responsible social services agency assists the youth in obtaining the following documents before the youth leaves foster care: a Social Security card; an official or certified copy of the youth's birth certificate; a state identification card or driver's license, Tribal enrollment identification card, ~~green~~ permanent resident card, or school visa; health insurance information; the youth's school, medical, and dental records; a contact list of the youth's medical, dental, and mental health providers; and contact information for the youth's siblings, if the siblings are in foster care.

(d) For a youth who will be discharged from foster care at 18 years of age or older because the youth is not eligible for extended foster care benefits or chooses to leave foster care, the responsible social services agency must develop a personalized transition plan as directed by the youth during the 180-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the youth elects and include specific options, including but not limited to:

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services;

(5) workforce supports and employment services;

(6) a copy of the youth's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the youth;

(7) information on executing a health care directive under chapter 145C and on the importance of designating another individual to make health care decisions on behalf of the youth if the youth becomes unable to participate in decisions;

(8) appropriate contact information through 21 years of age if the youth needs information or help dealing with a crisis situation; and

(9) official documentation that the youth was previously in foster care.

Sec. 25. Minnesota Statutes 2024, section 260E.03, subdivision 15, is amended to read:

Subd. 15. **Neglect.** (a) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (8), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(6) medical neglect, as defined in section 260C.007, subdivision 6, clause (5);

(7) chronic and severe use of alcohol or a controlled substance by a person responsible for the child's care that adversely affects the child's basic needs and safety; or

(8) emotional harm from a pattern of behavior that contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(b) Nothing in this chapter shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care.

(c) This chapter does not impose upon persons not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care a duty to provide that care.

(d) Nothing in this chapter shall be construed to mean that a child who has a mental, physical, or emotional condition is neglected solely because the child remains in an emergency department or hospital setting because services, including residential treatment, that are deemed necessary by the child's medical or mental health care professional or county

case manager are not available to the child's parent, guardian, or other person responsible for the child's care, and the child cannot be safely discharged to the child's family.

Sec. 26. Minnesota Statutes 2024, section 260E.09, is amended to read:

260E.09 REPORTING REQUIREMENTS.

(a) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required under section 260E.06, subdivision 1, to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the appropriate police department, the county sheriff, the agency responsible for assessing or investigating the report, or the local welfare agency.

(b) Any report shall be of sufficient content to identify the child, any person believed to be responsible for the maltreatment of the child if the person is known, the nature and extent of the maltreatment, and the name and address of the reporter. The local welfare agency or agency responsible for assessing or investigating the report shall accept a report made under section 260E.06 notwithstanding refusal by a reporter to provide the reporter's name or address as long as the report is otherwise sufficient under this paragraph. The local welfare agency or agency responsible for assessing or investigating the report shall ask the reporter if the reporter is aware of the child or family heritage, including the child's Tribal lineage pursuant to section 260.761 and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10.

(c) Notwithstanding paragraph (a), upon implementation of the provider licensing and reporting hub, an individual who has an account with the provider licensing and reporting hub and is required to report suspected maltreatment at a licensed program under section 260E.06, subdivision 1, may submit a written report in the hub in a manner prescribed by the commissioner and is not required to make an oral report. A report submitted through the provider licensing and reporting hub must be made immediately.

Sec. 27. Minnesota Statutes 2024, section 260E.20, subdivision 1, is amended to read:

Subdivision 1. **General duties.** (a) The local welfare agency shall offer services to prevent future maltreatment, safeguarding and enhancing the welfare of the maltreated child, and supporting and preserving family life whenever possible.

(b) If the report alleges a violation of a criminal statute involving maltreatment or child endangerment under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and

assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of the agency's investigation or assessment.

(c) In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred.

(d) When necessary, the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living.

(e) In performing any of these duties, the local welfare agency shall maintain an appropriate record.

(f) In conducting a family assessment, noncaregiver human trafficking assessment, or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence.

(g) If the family assessment, noncaregiver human trafficking assessment, or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency must coordinate a comprehensive assessment pursuant to section 245G.05.

(h) The agency may use either a family assessment or investigation to determine whether the child is safe when responding to a report resulting from birth match data under section 260E.03, subdivision 23, paragraph (c). If the child subject of birth match data is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(i) When conducting any assessment or investigation, the agency shall ask the child, if age appropriate; parents; extended family; and reporter about the child's family heritage, including the child's Tribal lineage pursuant to section 260.761 and the child's race, culture, and ethnicity pursuant to section 260.63, subdivision 10.

Sec. 28. Minnesota Statutes 2024, section 260E.24, subdivision 1, is amended to read:

Subdivision 1. **Timing.** The local welfare agency shall conclude the family assessment, the noncaregiver human trafficking assessment, or the investigation within 45 days of the receipt of a report. The conclusion of the assessment or investigation may be extended to

permit the completion of a criminal investigation or the receipt of expert information requested within 45 days of the receipt of the report.

Sec. 29. Minnesota Statutes 2024, section 260E.24, subdivision 2, is amended to read:

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

Sec. 30. **[260E.291] REPORTING OF SCHOOL ATTENDANCE CONCERNS.**

Subdivision 1. **Reports required.** (a) A person mandated to report under this chapter must immediately report to the local welfare agency, Tribal social services agency, or designated partner if the person knows or has reason to believe that a child required to be enrolled in school under section 120A.22 has at least seven unexcused absences in the current school year and is at risk of educational neglect under section 260C.163, subdivision 11.

(b) Any person may voluntarily report to the local welfare agency, Tribal social services agency, or designated partner if the person knows or has reason to believe that a child required to be enrolled in school under section 120A.22 has at least seven unexcused absences in the current school year and is at risk of educational neglect under section 260C.163, subdivision 11.

(c) An oral report must be made immediately by telephone or otherwise. An oral report made by a person required to report under paragraph (a) must be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the local welfare agency. A report must sufficiently identify the child and the child's parent or guardian, the actual or estimated number of the child's unexcused absences in the current school year, the efforts made by school officials to resolve attendance concerns with the family, and the name and address of the reporter. A voluntary reporter under paragraph (b) may refuse to provide their name or address if the report is otherwise sufficient, and such a report must be accepted by the local welfare agency.

Subd. 2. **Local welfare agency.** (a) The local welfare agency or partner designated to provide child welfare services must provide a child welfare response for a report that alleges

a child enrolled in school has seven or more unexcused absences. When providing a child welfare response under this paragraph, the local welfare agency or designated partner must offer services to the child and the child's family to address school attendance concerns or may partner with a county attorney's office, a community-based organization, or other community partner to provide the services. The services must be culturally and linguistically appropriate and tailored to the needs of the child and the child's family. This section is subject to all requirements of the Minnesota Indian Family Preservation Act under sections 260.751 to 260.835, and the Minnesota African American Family Preservation and Child Welfare Disproportionality Act under sections 260.61 to 260.693.

(b) If the child's unexcused absences continue and the family has not engaged with services under paragraph (a) after the local welfare agency, Tribal social services agency, or partner designated to provide child welfare services has made multiple varied attempts to engage the child's family, a report of educational neglect must be made regardless of the number of unexcused absences the child has accrued. The local welfare agency must determine the response path assignment pursuant to section 260E.17 and may proceed with the process outlined in section 260C.141.

Sec. 31. **REVISOR INSTRUCTION.**

The revisor of statutes shall change paragraphs to subdivisions, clauses to paragraphs, and items to clauses in Minnesota Statutes, sections 260C.203 and 260C.204. The revisor shall make any necessary grammatical changes or changes to sentence structure necessary to preserve the meaning of the text as a result of the changes. The revisor of statutes must correct any statutory cross-references consistent with the changes in this section.

ARTICLE 19
EARLY CARE AND LEARNING

Section 1. Minnesota Statutes 2024, section 142A.76, subdivision 2, is amended to read:

Subd. 2. **Establishment.** The Office of Restorative Practices is established within the Department of ~~Public Safety~~ Children, Youth, and Families. The Office of Restorative Practices shall have the powers and duties described in this section.

Sec. 2. Minnesota Statutes 2024, section 142A.76, subdivision 3, is amended to read:

Subd. 3. **Director; other staff.** (a) The commissioner of ~~public safety~~ children, youth, and families shall appoint a director of the Office of Restorative Practices. The director should have qualifications that include or are similar to the following:

(1) experience in the many facets of restorative justice and practices such as peacemaking circles, sentencing circles, community conferencing, community panels, and family group decision making;

(2) experience in victim-centered and trauma-informed practices;

(3) knowledge of the range of social problems that bring children and families to points of crisis such as poverty, racism, unemployment, and unequal opportunity;

(4) knowledge of the many ways youth become involved in other systems such as truancy, juvenile delinquency, and child protection; and

(5) understanding of educational barriers.

(b) The director shall hire additional staff to perform the duties of the Office of Restorative Practices. The staff shall be in the classified service of the state and their compensation shall be established pursuant to chapter 43A.

Sec. 3. Minnesota Statutes 2024, section 142D.31, subdivision 2, is amended to read:

Subd. 2. **Program components.** (a) The nonprofit organization must use the grant for:

(1) tuition scholarships ~~up to $10,000 per year~~ in amounts per year consistent with the national TEACH early childhood program requirements for courses leading to the nationally recognized child development associate credential or college-level courses leading to an associate's degree or bachelor's degree in early childhood development and school-age care; and

(2) education incentives of a minimum of $250 to participants in the tuition scholarship program if they complete a year of working in the early care and education field.

(b) Applicants for the scholarship must be employed by a licensed or certified early childhood or child care program and working directly with children, a licensed family child care provider, employed by a public prekindergarten program, employed by a Head Start program, or an employee in a school-age program exempt from licensing under section 142B.05, subdivision 2, paragraph (a), clause (8). Lower wage earners must be given priority in awarding the tuition scholarships. Scholarship recipients must contribute at least ten percent of the total scholarship and must be sponsored by their employers, who must also contribute at least five percent of the total scholarship. Scholarship recipients who ~~are self-employed~~ work in licensed family child care under Minnesota Rules, chapter 9502, must contribute ~~20~~ at least ten percent of the total scholarship and are not required to receive employer sponsorship or employer match.

Sec. 4. Minnesota Statutes 2024, section 142E.03, subdivision 3, is amended to read:

Subd. 3. **Redeterminations.** (a) Notwithstanding Minnesota Rules, part 3400.0180, item A, the county shall conduct a redetermination according to paragraphs (b) and (c).

(b) The county shall use the redetermination form developed by the commissioner. The county must verify the factors listed in subdivision 1, paragraph (a), as part of the redetermination.

(c) An applicant's eligibility must be redetermined no more frequently than every 12 months. The following criteria apply:

(1) a family meets the eligibility redetermination requirements if a complete redetermination form and all required verifications are received within 30 days after the date the form was due;

(2) if the 30th day after the date the form was due falls on a Saturday, Sunday, or holiday, the 30-day time period is extended to include the next day that is not a Saturday, Sunday, or holiday. Assistance shall be payable retroactively from the redetermination due date;

(3) for a family where at least one parent is younger than 21 years of age, does not have a high school degree or commissioner of education-selected high school equivalency certification, and is a student in a school district or another similar program that provides or arranges for child care, parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility may be deferred beyond 12 months, to the end of the student's school year; ~~and~~

(4) starting May 25, 2026, if a new eligible child is added to the family and has care authorized, the redetermination of eligibility must be extended 12 months from the eligible child's arrival date; and

~~(4)~~ (5) a family and the family's providers must be notified that the family's redetermination is due at least 45 days before the end of the family's 12-month eligibility period.

Sec. 5. Minnesota Statutes 2024, section 142E.11, subdivision 1, is amended to read:

Subdivision 1. **General authorization requirements.** (a) When authorizing the amount of child care, the county agency must consider the amount of time the parent reports on the application or redetermination form that the child attends preschool, a Head Start program, or school while the parent is participating in an authorized activity.

(b) Care must be authorized and scheduled with a provider based on the applicant's or participant's verified activity schedule when:

(1) the family requests care from more than one provider per child;

(2) the family requests care from a legal nonlicensed provider; or

(3) an applicant or participant is employed by any child care center that is licensed by the Department of Children, Youth, and Families or has been identified as a high-risk Medicaid-enrolled provider.

This paragraph expires March 2, 2026.

(c) If the family remains eligible at redetermination, a new authorization with fewer hours, the same hours, or increased hours may be determined.

Sec. 6. Minnesota Statutes 2024, section 142E.11, subdivision 2, is amended to read:

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 142E.12 for employment, education, or an MFIP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 142E.12, subdivision 3, or has an MFIP employment plan; or

(2) when the participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

(d) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not

apply to a family subject to subdivision 1, paragraph (b). This paragraph expires March 2, 2026.

(e) When a child reaches 13 years of age or a child with a disability reaches 15 years of age, the amount of child care authorized shall continue at the same number of hours or more hours until redetermination.

Sec. 7. Minnesota Statutes 2024, section 142E.13, subdivision 2, is amended to read:

Subd. 2. **Extended eligibility and redetermination.** (a) If the family received three months of extended eligibility and redetermination is not due, to continue receiving child care assistance the participant must be employed or have an education plan that meets the requirements of section 142E.12, subdivision 3, or have an MFIP employment plan. Notwithstanding Minnesota Rules, part 3400.0110, if child care assistance continues, the amount of child care authorized shall continue at the same number or more hours until redetermination, unless a condition in section 142E.11, subdivision 2, paragraph (c), applies. ~~A family subject to section 142E.11, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.~~

(b) If the family's redetermination occurs before the end of the three-month extended eligibility period to continue receiving child care assistance, the participant must verify that the participant meets eligibility and activity requirements for child care assistance under this chapter. If child care assistance continues, the amount of child care authorized is based on section 142E.12. ~~A family subject to section 142E.11, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.~~

EFFECTIVE DATE. This section is effective May 25, 2026.

Sec. 8. Minnesota Statutes 2024, section 142E.15, subdivision 1, is amended to read:

Subdivision 1. **Fee schedule.** All changes to parent fees must be implemented on the first Monday of the service period following the effective date of the change.

PARENT FEE SCHEDULE. The parent fee schedule is as follows, except as noted in subdivision 2:

Income Range (as a percent of the state median income, except at the start of the first tier)	Co-payment (as a percentage of adjusted gross income)
~~0-74.99%~~ 0-99.99% of federal poverty guidelines	$0/biweekly
~~75.00-99.99% of federal poverty guidelines~~	~~$2/biweekly~~

100.00% of federal poverty guidelines-~~27.72%~~ 27.99%	~~2.61%~~ 2.6%
~~27.73-29.04%~~	~~2.61%~~
~~29.05-30.36%~~	~~2.61%~~
~~30.37-31.68%~~	~~2.61%~~
~~31.69-33.00%~~	~~2.91%~~
~~33.01-34.32%~~	~~2.91%~~
~~34.33-35.65%~~	~~2.91%~~
~~35.66-36.96%~~	~~2.91%~~
~~36.97-38.29%~~	~~3.21%~~
~~38.30-39.61%~~	~~3.21%~~
~~39.62-40.93%~~	~~3.21%~~
~~40.94-42.25%~~	~~3.84%~~
~~42.26-43.57%~~	~~3.84%~~
~~43.58-44.89%~~	~~4.46%~~
~~44.90-46.21%~~	~~4.76%~~
~~46.22-47.53%~~	~~5.05%~~
~~47.54-48.85%~~	~~5.65%~~
~~48.86-50.17%~~	~~5.95%~~
~~50.18-51.49%~~	~~6.24%~~
~~51.50-52.81%~~	~~6.84%~~
~~52.82-54.13%~~	~~7.58%~~
~~54.14-55.45%~~	~~8.33%~~
~~55.46-56.77%~~	~~9.20%~~
~~56.78-58.09%~~	~~10.07%~~
~~58.10-59.41%~~	~~10.94%~~
~~59.42-60.73%~~	~~11.55%~~
~~60.74-62.06%~~	~~12.16%~~
~~62.07-63.38%~~	~~12.77%~~
~~63.39-64.70%~~	~~13.38%~~
~~64.71-67.00%~~	~~14.00%~~
28.00-30.99%	2.6%
31.00-33.99%	2.6%
34.00-36.99%	2.9%
37.00-39.99%	3.2%
40.00-42.99%	3.8%
43.00-45.99%	4.4%
46.00-48.99%	5.0%

49.00-51.99%	5.6%
52.00-54.99%	6.2%
55.00-57.99%	6.8%
58.00-60.99%	6.9%
61.00-63.99%	6.9%
64.00-67.00%	6.9%
Greater than 67.00%	ineligible

A family's biweekly co-payment fee is the fixed percentage established for the income range multiplied by the ~~highest~~ lowest possible income within that income range.

EFFECTIVE DATE. This section is effective October 13, 2025.

Sec. 9. Minnesota Statutes 2024, section 142E.16, subdivision 3, is amended to read:

Subd. 3. **Training required.** (a) Prior to initial authorization as required in subdivision 1, a legal nonlicensed family child care provider must complete first aid and CPR training and provide the verification of first aid and CPR training to the commissioner. The training documentation must have valid effective dates as of the date the registration request is submitted to the commissioner. The training must have been provided by an individual approved to provide first aid and CPR instruction and have included CPR techniques for infants and children.

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

(c) Every 12 months, a legal nonlicensed family child care provider who is unrelated to the child they care for must complete two hours of training in caring for children approved by the commissioner.

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

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

Sec. 10. Minnesota Statutes 2024, section 142E.16, subdivision 7, is amended to read:

Subd. 7. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must:

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

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

(3) submit data on child enrollment and attendance in the form and manner specified by the commissioner.

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

(c) When the county or the commissioner knows or has reason to believe that a current or former provider has not complied with the record-keeping requirement in this subdivision:

(1) the commissioner may:

(i) deny or revoke a provider's authorization to receive child care assistance payments under section 142E.17, subdivision 9, paragraph (d);

(ii) pursue an administrative disqualification under sections 142E.51, subdivision 5, and 256.98; or

(iii) take an action against the provider under ~~sections 142E.50 to 142E.58~~ section 142E.51; or

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

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

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

EFFECTIVE DATE. This section is effective June 22, 2026.

Sec. 11. Minnesota Statutes 2024, section 245.975, subdivision 1, is amended to read:

Subdivision 1. **Creation and appointment.** The Office of the Ombudsperson for Family Child Care Providers is hereby created. The governor shall appoint an ombudsperson in the unclassified service to assist family child care providers with licensing, compliance, and other issues facing family child care providers. The ombudsperson must be selected without regard to the person's political affiliation and must have been a licensed family child care provider for at least three years. The ombudsperson shall serve a term of four years, which may be renewed, and may be removed prior to the end of the term for just cause.

Sec. 12. **ELIMINATING SCHEDULE REPORTER DESIGNATION.**

Notwithstanding Minnesota Statutes, section 142E.04, subdivisions 6, 7, and 8, the commissioner of children, youth, and families must allocate additional basic sliding fee child care money for calendar years 2026 and 2027 to counties and Tribes to account for eliminating the schedule reporter designation in the child care assistance program. In allocating the additional money, the commissioner shall consider:

(1) the number of children who are in schedule reporter families; and

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

Sec. 13. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245.0962, as Minnesota Statutes, section 142A.47. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

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

Sec. 14. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 142D.12, subdivision 3, as Minnesota Statutes, section 120B.121. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

Sec. 15. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 124D.129, as Minnesota Statutes, section 142A.48. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

ARTICLE 20

CHILDREN AND FAMILIES LICENSING POLICY

Section 1. Minnesota Statutes 2024, section 142B.10, subdivision 14, is amended to read:

Subd. 14. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 142B.11. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

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

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

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

(1) the commissioner is unable to conduct the observation required by subdivision 11, paragraph (a), clause (3), because the program is not yet operational;

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

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

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

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

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

(2) been denied a license under this chapter or chapter 245A within the past two years;

(3) had a license issued under this chapter or chapter 245A revoked within the past five years; or

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

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

(e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license affiliated with a license holder or controlling individual that had a license revoked within the past five years if the commissioner determines that (1) the license holder or controlling individual is operating the program in substantial compliance with applicable laws and rules and (2) the program's continued operation is in the best interests of the community being served.

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

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

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

(i) Pursuant to section 142B.18, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

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

(k) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

(l) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must ~~apply for and be granted~~ comply with the requirements in section 142B.12 and be reissued a new license to operate the program or the program must not be operated after the expiration date. Child foster care license holders must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

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

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

Sec. 2. Minnesota Statutes 2024, section 142B.16, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the Department of Children, Youth, and Families to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration

must be made in writing and must be postmarked and sent to the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder or submitted in the provider licensing and reporting hub within 20 calendar days from the date the commissioner issued the order through the hub, and:

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

(2) explain why they are in error; and

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

(b) Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration. A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

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

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

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

(d) The commissioner must not publicly post the correction order for licensed child care centers or licensed family child care providers on the department's website until:

(1) after the 20-calendar-day period for requesting reconsideration; or

(2) if the applicant or license holder requested reconsideration, after the commissioner's disposition of a request for reconsideration is provided to the applicant or license holder.

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

Sec. 3. Minnesota Statutes 2024, section 142B.171, subdivision 2, is amended to read:

Subd. 2. **Documented technical assistance.** (a) In lieu of a correction order under section 142B.16, the commissioner shall provide documented technical assistance to a family child care or child care center license holder if the commissioner finds that:

(1) the license holder has failed to comply with a requirement in this chapter or Minnesota Rules, chapter 9502 or 9503, that the commissioner determines to be low risk as determined by the child care weighted risk system;

(2) the noncompliance does not imminently endanger the health, safety, or rights of the persons served by the program; and

(3) the license holder did not receive documented technical assistance or a correction order for the same violation at the license holder's most recent annual licensing inspection.

(b) Documented technical assistance must include communication from the commissioner to the license holder that:

(1) states the conditions that constitute a violation of a law or rule;

(2) references the specific law or rule violated; and

(3) explains remedies for correcting the violation.

~~(c) The commissioner shall not publicly publish documented technical assistance on the department's website.~~

Sec. 4. **[142B.181] POSTING LICENSING ACTIONS ON DEPARTMENT WEBSITE.**

(a) The commissioner must post a summary document for each licensing action issued to a licensed child care center and family child care provider on the Licensing Information Lookup public website maintained by the Department of Children, Youth, and Families. The commissioner must not post any communication, including letters, from the commissioner to the center or provider.

(b) The commissioner must remove a summary document from the Licensing Information Lookup public website within ten days of the length of time that the document is required to be posted under Code of Federal Regulations, title 45, section 98.33.

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

Sec. 5. Minnesota Statutes 2024, section 142B.30, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 142B.10; to recommend denial of applicants under section 142B.15; to issue correction orders, to issue variances, and to recommend a conditional license under section 142B.16; or to recommend suspending or revoking a license or issuing a fine under section 142B.18, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and family child foster care;

(2) child foster care maximum age requirement;

(3) variances regarding disqualified individuals;

(4) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder; and

(5) variances to section 142B.74 for a time-limited period. If the commissioner grants a variance under this clause, the license holder must provide notice of the variance to all parents and guardians of the children in care.

(b) The commissioners of human services and children, youth, and families must both approve a variance for dual licensure of family child foster care and family adult foster care or family adult foster care and family child care. Variances under this paragraph are excluded from the delegation of variance authority and may be issued only by both commissioners.

(c) Except as provided in section 142B.41, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(d) A county agency that has been designated by the commissioner to issue family child care variances must:

(1) publish the county agency's policies and criteria for issuing variances on the county's public website and update the policies as necessary; and

(2) annually distribute the county agency's policies and criteria for issuing variances to all family child care license holders in the county.

(e) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(f) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing review at least annually.

(g) A child foster care license issued under this section may be issued for up to two years until implementation of the provider licensing and reporting hub. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

(h) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, and any licensing correction order issued;

(2) any death, serious injury, or determination of substantiated maltreatment; and

(3) any fires that require the service of a fire department within 48 hours of the fire. The information under this clause must also be reported to the state fire marshal within two business days of receiving notice from a licensed family child care provider.

Sec. 6. Minnesota Statutes 2024, section 142B.41, is amended by adding a subdivision to read:

Subd. 14. **Staff distribution.** Notwithstanding Minnesota Rules, part 9503.0040, subpart 2, item B, a child care aide in a licensed child care center may be substituted for a teacher during morning arrival and afternoon departure times if the total arrival and departure time does not exceed 25 percent of the center's daily hours of operation. For a child care aide to be substituted for a teacher under this subdivision, the child care aide must:

(1) be 18 years of age or older;

(2) have been employed by the child care center for a minimum of 30 days; and

(3) have completed the training required under section 142B.65, including orientation training and the training required within the first 90 days of employment.

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

Sec. 7. Minnesota Statutes 2024, section 142B.51, subdivision 2, is amended to read:

Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs licensed by the Department of Human Services under chapter 245A or the Department of Children, Youth, and Families under this chapter and Minnesota Rules, chapter 2960, that serve a child or children under ~~eight~~ nine years of age must document training that fulfills the requirements in this subdivision.

(b) Before a license holder, staff person, or caregiver transports a child or children under age ~~eight~~ nine in a motor vehicle, the person transporting the child must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this section may be used to meet initial or ongoing training under Minnesota Rules, part 2960.3070, subparts 1 and 2.

(c) Training required under this section must be completed at orientation or initial training and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(d) Training under paragraph (c) must be provided by individuals who are certified and approved by the Office of Traffic Safety within the Department of Public Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

~~(e) Notwithstanding paragraph (a), for an emergency relative placement under section 142B.06, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety check up. The child seat safety check up trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one-on-one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety check up must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the other requirements of this subdivision prior to placement of another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.~~

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

Sec. 8. Minnesota Statutes 2024, section 142B.65, subdivision 8, is amended to read:

Subd. 8. **Child passenger restraint systems; training requirement.** (a) Before a license holder transports a child or children under age ~~eight~~ nine in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles.

(b) Training required under this subdivision must be repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(c) Training required under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(d) Child care providers that only transport school-age children as defined in section 142B.01, subdivision 25, in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

(e) Training completed under this subdivision may be used to meet in-service training requirements under subdivision 9. Training completed within the previous five years is transferable upon a staff person's change in employment to another child care center.

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

Sec. 9. Minnesota Statutes 2024, section 142B.65, subdivision 9, is amended to read:

Subd. 9. **In-service training.** (a) A license holder must ensure that the center director, staff persons, substitutes, and unsupervised volunteers complete in-service training each calendar year.

(b) The center director and staff persons who work more than 20 hours per week must complete 24 hours of in-service training each calendar year. Staff persons who work 20 hours or less per week must complete 12 hours of in-service training each calendar year. Substitutes and unsupervised volunteers must complete at least two hours of training each year, and the training must include the requirements of paragraphs (d) to (g) ~~and do not otherwise have a minimum number of hours of training to complete~~.

(c) The number of in-service training hours may be prorated for ~~individuals~~ center directors and staff persons not employed for an entire year.

(d) Each year, in-service training must include:

(1) the center's procedures for maintaining health and safety according to section 142B.66 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) the reporting responsibilities under chapter 260E and Minnesota Rules, part 9503.0130;

(3) at least one-half hour of training on the standards under section 142B.46 and on reducing the risk of sudden unexpected infant death as required under subdivision 6, if applicable; and

(4) at least one-half hour of training on the risk of abusive head trauma from shaking infants and young children as required under subdivision 7, if applicable.

(e) Each year, or when a change is made, whichever is more frequent, in-service training must be provided on: (1) the center's risk reduction plan under section 142B.54, subdivision 2; and (2) a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3.

(f) At least once every two calendar years, the in-service training must include:

(1) child development and learning training under subdivision 3;

(2) pediatric first aid that meets the requirements of subdivision 4;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 5;

(4) cultural dynamics training to increase awareness of cultural differences; and

(5) disabilities training to increase awareness of differing abilities of children.

(g) At least once every five years, in-service training must include child passenger restraint training that meets the requirements of subdivision 8, if applicable.

(h) The remaining hours of the in-service training requirement must be met by completing training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning;

(2) Content area II: developmentally appropriate learning experiences;

(3) Content area III: relationships with families;

(4) Content area IV: assessment, evaluation, and individualization;

(5) Content area V: historical and contemporary development of early childhood education;

(6) Content area VI: professionalism;

(7) Content area VII: health, safety, and nutrition; and

(8) Content area VIII: application through clinical experiences.

(i) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child development and learning training" means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

(4) "Assessment, evaluation, and individualization" means training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality.

(5) "Historical and contemporary development of early childhood education" means training in past and current practices in early childhood education and how current events and issues affect children, families, and programs.

(6) "Professionalism" means training in knowledge, skills, and abilities that promote ongoing professional development.

(7) "Health, safety, and nutrition" means training in establishing health practices, ensuring safety, and providing healthy nutrition.

(8) "Application through clinical experiences" means clinical experiences in which a person applies effective teaching practices using a range of educational programming models.

(j) The license holder must ensure that documentation, as required in subdivision 10, includes the number of total training hours required to be completed, name of the training, the Minnesota Knowledge and Competency Framework content area, number of hours completed, and the director's approval of the training.

(k) In-service training completed by a staff person that is not specific to that child care center is transferable upon a staff person's change in employment to another child care program.

Sec. 10. Minnesota Statutes 2024, section 142B.66, subdivision 3, is amended to read:

Subd. 3. **Emergency preparedness.** (a) A licensed child care center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to a child. The plan must be written on a form developed by the commissioner and must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis;

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

(b) The license holder must train staff persons on the emergency plan at orientation, when changes are made to the plan, and at least once each calendar year. Training must be documented in each staff person's personnel file.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

(d) The license holder must review and update the emergency plan ~~annually~~ each calendar year. Documentation of the ~~annual~~ yearly emergency plan review shall be maintained in the program's administrative records.

(e) The license holder must include the emergency plan in the program's policies and procedures as specified under section 142B.10, subdivision 21. The license holder must

provide a physical or electronic copy of the emergency plan to the child's parent or legal guardian upon enrollment.

(f) The relocation site and evacuation route must be posted in a visible place as part of the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140, subpart 21.

Sec. 11. Minnesota Statutes 2024, section 142B.70, subdivision 7, is amended to read:

Subd. 7. **Child passenger restraint systems; training requirement.** (a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

(b) Family and group family child care programs licensed by the Department of Children, Youth, and Families that serve a child or children under ~~eight~~ nine years of age must document training that fulfills the requirements in this subdivision.

(1) Before a license holder, second adult caregiver, substitute, or helper transports a child or children under age ~~eight~~ nine in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this subdivision may be used to meet initial training under subdivision 1 or ongoing training under subdivision 8.

(2) Training required under this subdivision must be at least one hour in length, completed at initial training, and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(3) Training under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(c) Child care providers that only transport school-age children as defined in section 142B.01, subdivision 13, paragraph (f), in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

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

Sec. 12. Minnesota Statutes 2024, section 142B.70, subdivision 8, is amended to read:

Subd. 8. **Training requirements for family and group family child care.** (a) For purposes of family and group family child care, the license holder and each second adult caregiver must complete 16 hours of ongoing training each year. Repeat of topical training requirements in subdivisions 3 to 9 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

(1) child development and learning training in understanding how a child develops physically, cognitively, emotionally, and socially, and how a child learns as part of the child's family, culture, and community;

(2) developmentally appropriate learning experiences, including training in creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, promoting creative development; and behavior guidance;

(3) relationships with families, including training in building a positive, respectful relationship with the child's family;

(4) assessment, evaluation, and individualization, including training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality;

(5) historical and contemporary development of early childhood education, including training in past and current practices in early childhood education and how current events and issues affect children, families, and programs;

(6) professionalism, including training in knowledge, skills, and abilities that promote ongoing professional development; and

(7) health, safety, and nutrition, including training in establishing healthy practices; ensuring safety; and providing healthy nutrition.

(b) A provider who is approved as a trainer through the Develop data system may count up to two hours of training instruction toward the annual 16-hour training requirement in paragraph (a). The provider may only count training instruction hours for the first instance in which they deliver a particular content-specific training during each licensing year. Hours counted as training instruction must be approved through the Develop data system with attendance verified on the trainer's individual learning record and must be in Knowledge

and Competency Framework content area VII A (Establishing Healthy Practices) or B (Ensuring Safety).

(c) Substitutes and adult caregivers who provide care for 500 or fewer hours per year must complete a minimum of one hour of training each calendar year, and the training must include the requirements in subdivisions 3, 4, 5, 6, and 9.

Sec. 13. Minnesota Statutes 2024, section 142C.06, is amended by adding a subdivision to read:

Subd. 4. **Requirement to post conditional certification.** Upon receipt of any order of conditional certification issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the order of conditional certification by the certification holder, the certification holder shall post the order of conditional certification in a place that is conspicuous to the people receiving services and all visitors to the facility for the duration of the conditional certification. When the order of conditional certification is accompanied by a maltreatment investigation memorandum prepared under chapter 260E, the investigation memoranda must be posted with the order of conditional certification.

Sec. 14. Minnesota Statutes 2024, section 142C.11, subdivision 8, is amended to read:

Subd. 8. **Required policies.** A certified center must have written policies for health and safety items in subdivisions 1 to 6, 9, and 10.

Sec. 15. Minnesota Statutes 2024, section 142C.12, subdivision 1, is amended to read:

Subdivision 1. **First aid and cardiopulmonary resuscitation.** (a) Before having unsupervised direct contact with a child, but within 90 days after the first date of direct contact with a child, the director, all staff persons, substitutes, and unsupervised volunteers must successfully complete pediatric first aid and pediatric cardiopulmonary resuscitation (CPR) training, unless the training has been completed within the previous two calendar years. Staff must complete the pediatric first aid and pediatric CPR training at least every other calendar year and the center must document the training in the staff person's personnel record.

(b) Training completed under this subdivision may be used to meet the in-service training requirements under subdivision 6.

(c) Training must include CPR and techniques for providing immediate care to people experiencing life-threatening cardiac emergencies, choking, bleeding, fractures and sprains, head injuries, poisoning, and burns. Training developed by the American Heart Association,

the American Red Cross, or another organization that uses nationally recognized, evidence-based guidelines meets these requirements.

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

Sec. 16. Minnesota Statutes 2024, section 142C.12, subdivision 6, is amended to read:

Subd. 6. **In-service training.** (a) The certified center must ensure that the director and all staff persons, including substitutes and unsupervised volunteers, are trained at least once each calendar year on health and safety requirements in this section and sections 142C.10, 142C.11, and 142C.13.

(b) The director and each staff person, not including substitutes, must complete at least six hours of training each calendar year. Substitutes must complete at least two hours of training each calendar year. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision.

Sec. 17. Minnesota Statutes 2024, section 245A.18, subdivision 1, is amended to read:

Subdivision 1. **Seat belt and child passenger restraint system use.** All license holders that transport children must comply with the requirements of section 142B.51, subdivision 1, and license holders that transport a child or children under ~~eight~~ nine years of age must document training that fulfills the requirements in section 142B.51, subdivision 2.

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

Sec. 18. Laws 2021, First Special Session chapter 7, article 2, section 81, is amended to read:

Sec. 81. **FAMILY CHILD CARE REGULATION MODERNIZATION.**

(a) The commissioner of ~~human services shall~~ children, youth, and families must contract with an experienced and independent organization or individual consultant to conduct the work outlined in this section. If practicable, the commissioner must contract with the National Association for Regulatory Administration.

(b) The consultant must develop a proposal for updated family child care licensing standards and solicit input from stakeholders as described in paragraph (d). The proposed new standards must protect the health and safety of children in family child care programs and be child centered, family friendly, and fair to providers.

(c) The consultant must work with stakeholders and the Department of Children, Youth, and Families, as described in paragraph (d), to develop a proposal for a risk-based model for monitoring compliance with family child care licensing standards~~, grounded in national regulatory best practices~~. Violations in the new model must be weighted to reflect the potential risk they pose to children's health and safety, and licensing sanctions must be tied to the potential risk. ~~The proposed new model must protect the health and safety of children in family child care programs and be child-centered, family-friendly, and fair to providers.~~

(d) The consultant ~~shall~~ must develop and implement a stakeholder engagement process that solicits input from parents, licensed family child care providers, county licensors, staff of the Department of ~~Human Services~~ Children, Youth, and Families, and experts in child development about licensing standards, tiers for violations of the standards based on the potential risk of harm that each violation poses, and licensing sanctions for each tier. The consultant and commissioner must engage with working groups of licensed family child care providers at least five times throughout the stakeholder engagement process, and include both daytime and evening engagement opportunities as needed.

(e) The consultant shall solicit input from parents, licensed family child care providers, county licensors, and staff of the Department of ~~Human Services~~ Children, Youth, and Families about which family child care providers should be eligible for abbreviated inspections that predict compliance with other licensing standards for licensed family child care providers using key indicators previously identified by an empirically based statistical methodology developed by the National Association for Regulatory Administration and the Research Institute for Key Indicators.

(f) No later than ~~February~~ December 1, ~~2024~~ 2025, the commissioner ~~shall~~ must submit a report and proposed legislation required to implement the new licensing model and the new licensing standards to the chairs and ranking minority members of the legislative committees with jurisdiction over child care regulation. Throughout the drafting of the report and proposed legislation required under this paragraph, the commissioner must engage providers whose primary language is not English to have those providers review translated drafts of the report and written materials provided at engagement sessions to provide feedback on the draft standards. This engagement must occur within focus groups or meetings that are held at convenient times for the providers, including both daytime and evening sessions.

(g) The proposals developed under paragraphs (b) and (c); any presentations, summary documents, engagement invitations, surveys, and drafts of the report used in the stakeholder engagement process under paragraph (d) or when soliciting input under paragraph (e); and

the report required under paragraph (f) must also be made available in Hmong, Somali, and Spanish.

(h) The updated family child care licensing standards proposed under paragraph (b) and the risk-based model for monitoring compliance with family child care licensing standards proposed under paragraph (c) must not be implemented any earlier than January 1, 2027.

ARTICLE 21

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES RECODIFICATION CONFORMING CHANGES

Section 1. Minnesota Statutes 2024, section 3.922, subdivision 1, is amended to read:

Subdivision 1. **Creation, membership.** The state Indian Affairs Council is created to consist of the following members:

(1) one member of each of the following federally recognized tribes, designated by the elected tribal president or chairperson of the governing bodies of:

the Fond du Lac Band;

the Grand Portage Band;

the Mille Lacs Band;

the White Earth Band;

the Bois Forte (Nett Lake) Band;

the Leech Lake Band;

the Red Lake Nation;

the Upper Sioux Community;

the Lower Sioux Community;

the Shakopee Mdewakanton Sioux Community;

the Prairie Island Mdewakanton Dakota Community;

(2) a member of the governor's official staff designated by the governor;

the commissioner of education;

the commissioner of human services;

the commissioner of natural resources;

the commissioner of human rights;

the commissioner of employment and economic development;

the commissioner of corrections;

the commissioner of the Minnesota Housing Finance Agency;

the commissioner of Iron Range resources and rehabilitation;

the commissioner of health;

the commissioner of transportation;

the commissioner of veterans affairs;

the commissioner of administration;

the commissioner of children, youth, and families;

Each of the commissioners listed in this clause may designate a staff member to serve on the council instead of the commissioner;

(3) two members of the house of representatives, appointed by the speaker; and

(4) two members of the senate, appointed by its Subcommittee on Committees.

Members appointed to represent the house of representatives or the senate shall no longer serve on the council when they are no longer members of the bodies which they represent and their offices shall be vacant. A member who is a designee of a tribal president or chairperson shall cease to be a member at the end of the term of the designating tribal president or chairperson. Only members of the council designated under clause (1) shall vote.

Sec. 2. Minnesota Statutes 2024, section 13.41, subdivision 1, is amended to read:

Subdivision 1. **Definition.** As used in this section "licensing agency" means any board, department or agency of this state which is given the statutory authority to issue professional or other types of licenses, except the various agencies primarily administered by the commissioner of human services or the commissioner of children, youth, and families. Data pertaining to persons or agencies licensed or registered under authority of the commissioner of human services or the commissioner of children, youth, and families shall be administered pursuant to section 13.46.

Sec. 3. Minnesota Statutes 2024, section 13.46, subdivision 3, is amended to read:

Subd. 3. **Investigative data.** (a) Data on persons, including data on vendors of services, licensees, and applicants that is collected, maintained, used, or disseminated by the welfare

system in an investigation, authorized by statute, and relating to the enforcement of rules or law are confidential data on individuals pursuant to section 13.02, subdivision 3, or protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and shall not be disclosed except:

(1) pursuant to section 13.05;

(2) pursuant to statute or valid court order;

(3) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense;

(4) to an agent of the welfare system or an investigator acting on behalf of a county, state, or federal government, including a law enforcement officer or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding, unless the commissioner of human services or the commissioner of children, youth, and families determines that disclosure may compromise a Department of Human Services or Department of Children, Youth, and Families ongoing investigation; or

(5) to provide notices required or permitted by statute.

The data referred to in this subdivision shall be classified as public data upon submission to an administrative law judge or court in an administrative or judicial proceeding. Inactive welfare investigative data shall be treated as provided in section 13.39, subdivision 3.

(b) Notwithstanding any other provision in law, the commissioner of human services or the commissioner of children, youth, and families shall provide all active and inactive investigative data, including the name of the reporter of alleged maltreatment under section 626.557 or chapter 260E, to the ombudsman for mental health and developmental disabilities upon the request of the ombudsman.

(c) Notwithstanding paragraph (a) and section 13.39, the existence of an investigation by the commissioner of human services or the commissioner of children, youth, and families of possible overpayments of public funds to a service provider or recipient may be disclosed if the commissioner determines that it will not compromise the investigation.

Sec. 4. Minnesota Statutes 2024, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or

registration or who formerly were licensed or registered under the authority of the commissioner of human services or the commissioner of children, youth, and families;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, certification holders, and former licensees are public: name, address, telephone number of licensees, email addresses except for family child foster care, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services; the commissioner of children, youth, and families; the local social services agency; or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) Except as provided in item (v), when a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the general nature of the complaint or allegations leading to the temporary immediate suspension; the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence of settlement negotiations; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 142A.15 or 245A.05 or a sanction under section 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling individual is responsible for maltreatment under section 626.557 or chapter 260E, the identity

of the applicant, license holder, or controlling individual as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 142A.15 or 245A.05 or a sanction under section 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling individual is disqualified under chapter 245C, the identity of the license holder, applicant, or controlling individual as the disqualified individual is public data at the time of the issuance of the licensing sanction or denial. If the applicant, license holder, or controlling individual requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are private data.

(v) A correction order or fine issued to a child care provider for a licensing violation is private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

(2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(3) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the existence of settlement negotiations, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(4) When maltreatment is substantiated under section 626.557 or chapter 260E and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 142B or 245A; the commissioner of human services; commissioner of children, youth, and families; local social services agency; or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise

classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 142B, 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under section 626.557 and chapter 260E, are confidential data and may be disclosed only as provided in section 260E.21, subdivision 4; 260E.35; or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 260E.03, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35, subdivision 6, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.557 or chapter 260E may be exchanged with the Department of Health for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 142B, 245A, and 245C~~,~~ and data on individuals collected by the commissioner of human services or the commissioner of children, youth, and families according to investigations under

section 626.557 and chapters 142B, 245A, 245B, 245C, 245D, and 260E may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board and between the commissioners of human services and children, youth, and families when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services or children, youth, and families is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under sections 260E.24, subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the commissioner of human services; commissioner of children, youth, and families; or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 260E.03, and the commissioner of human services; commissioner of children, youth, and families; or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner of human services; commissioner of children, youth, and families; or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 5. Minnesota Statutes 2024, section 13.46, subdivision 9, is amended to read:

Subd. 9. **Fraud.** In cases of suspected fraud, in which access to mental health data maintained by public or private community mental health centers or mental health divisions of counties and other providers under contract to deliver mental health services is necessary

to a proper investigation, the county board or the appropriate prosecutorial authority shall refer the matter to the commissioner of human services or the commissioner of children, youth, and families. The commissioner and agents of the commissioner, while maintaining the privacy rights of individuals and families, shall have access to mental health data to conduct an investigation. Upon deeming it appropriate as a result of the investigation, the commissioner shall refer the matter to the appropriate legal authorities and may disseminate to those authorities whatever mental health data are necessary to properly prosecute the case.

Sec. 6. Minnesota Statutes 2024, section 13.46, subdivision 10, is amended to read:

Subd. 10. **Responsible authority.** (a) Notwithstanding any other provision of this chapter to the contrary, the responsible authority for each component of the welfare system listed in subdivision 1, clause (c), shall be as follows:

(1) the responsible authority for the Department of Human Services is the commissioner of human services;

(2) the responsible authority of a county welfare agency is the director of the county welfare agency;

(3) the responsible authority for a local social services agency, human services board, or community mental health center board is the chair of the board;

(4) the responsible authority of any person, agency, institution, organization, or other entity under contract to any of the components of the welfare system listed in subdivision 1, clause (c), is the person specified in the contract;

(5) the responsible authority of the public authority for child support enforcement is the head of the public authority for child support enforcement;

(6) the responsible authority for county veteran services is the county veterans service officer pursuant to section 197.603, subdivision 2; ~~and~~

(7) the responsible authority for Direct Care and Treatment is the chief executive officer of Direct Care and Treatment~~.~~; and

(8) the responsible authority for the Department of Children, Youth, and Families is the commissioner of children, youth, and families.

(b) A responsible authority shall allow another responsible authority in the welfare system access to data classified as not public data when access is necessary for the

administration and management of programs, or as authorized or required by statute or federal law.

Sec. 7. Minnesota Statutes 2024, section 13.598, subdivision 10, is amended to read:

Subd. 10. **Employment and training programs; data sharing.** Data sharing of employment and training program data between the commissioner of employment and economic development~~,~~; the commissioner of human services~~,~~; the commissioner of children, youth, and families; state agency personnel~~,~~; and other users of the inventory, referral and intake system~~,~~ is governed by section 116L.86, subdivision 3.

Sec. 8. Minnesota Statutes 2024, section 14.03, subdivision 3, is amended to read:

Subd. 3. **Rulemaking procedures.** (a) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules concerning only the internal management of the agency or other agencies that do not directly affect the rights of or procedures available to the public;

(2) an application deadline on a form; and the remainder of a form and instructions for use of the form to the extent that they do not impose substantive requirements other than requirements contained in statute or rule;

(3) the curriculum adopted by an agency to implement a statute or rule permitting or mandating minimum educational requirements for persons regulated by an agency, provided the topic areas to be covered by the minimum educational requirements are specified in statute or rule;

(4) procedures for sharing data among government agencies, provided these procedures are consistent with chapter 13 and other law governing data practices.

(b) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules of the commissioner of corrections relating to the release, placement, term, and supervision of inmates serving a supervised release or conditional release term, the internal management of institutions under the commissioner's control, and rules adopted under section 609.105 governing the inmates of those institutions;

(2) rules relating to weight limitations on the use of highways when the substance of the rules is indicated to the public by means of signs;

(3) opinions of the attorney general;

(4) the data element dictionary and the annual data acquisition calendar of the Department of Education to the extent provided by section 125B.07;

(5) the occupational safety and health standards provided in section 182.655;

(6) revenue notices and tax information bulletins of the commissioner of revenue;

(7) uniform conveyancing forms adopted by the commissioner of commerce under section 507.09;

(8) standards adopted by the Electronic Real Estate Recording Commission established under section 507.0945; ~~or~~

(9) the interpretive guidelines developed by the commissioner of human services to the extent provided in chapter 245A.~~;~~ or

(10) the interpretive guidelines developed by the commissioner of children, youth, and families to the extent provided in chapter 142B.

Sec. 9. Minnesota Statutes 2024, section 116L.881, is amended to read:

116L.881 INDIAN TRIBE PLANS.

(a) The commissioner, in consultation with the ~~commissioner~~ commissioners of human services and children, youth, and families, shall review and comment on Indian tribe plans submitted to the commissioner for provision of employment and training services. Beginning April 15, 1991, and by April 15 of each second year thereafter, the Indian tribe shall prepare and submit to the commissioner a plan that covers the next two state fiscal years. Beginning April 15, 1992, and by April 15 of each second year thereafter, the Indian tribe shall prepare and submit to the commissioner an interim year plan update that deals with performance during the past state fiscal year and that covers changes anticipated for the second year of the biennium. The commissioner shall notify the Indian tribe of approval or disapproval of the plans and updates for existing programs within 60 days of submission.

(b) A plan for a new tribal program must be submitted at least 45 days before the program is to commence. The commissioner shall approve or disapprove the plan for new programs within 30 days of receipt.

(c) The tribal plan and update must contain information that has been established by the commissioner and the ~~commissioner~~ commissioners of human services and children, youth, and families for the tribal employment and training service program.

(d) The commissioner may recommend to the ~~commissioner~~ commissioners of human services and children, youth, and families withholding the distribution of employment and

training money from a tribe whose plan or update is disapproved by the commissioner or a tribe that does not submit a plan or update by the date established in this section.

Sec. 10. Minnesota Statutes 2024, section 125A.15, is amended to read:

125A.15 PLACEMENT IN ANOTHER DISTRICT; RESPONSIBILITY.

The responsibility for special instruction and services for a child with a disability temporarily placed in another district for care and treatment shall be determined in the following manner:

(a) The district of residence of a child shall be the district in which the child's parent resides, if living, or the child's guardian. If there is a dispute between school districts regarding residency, the district of residence is the district designated by the commissioner.

(b) If a district other than the resident district places a pupil for care and treatment, the district placing the pupil must notify and give the resident district an opportunity to participate in the placement decision. When an immediate emergency placement of a pupil is necessary and time constraints foreclose a resident district from participating in the emergency placement decision, the district in which the pupil is temporarily placed must notify the resident district of the emergency placement within 15 days. The resident district has up to five business days after receiving notice of the emergency placement to request an opportunity to participate in the placement decision, which the placing district must then provide.

(c) When a child is temporarily placed for care and treatment in a day program located in another district and the child continues to live within the district of residence during the care and treatment, the district of residence is responsible for providing transportation to and from the care and treatment program and an appropriate educational program for the child. The resident district may establish reasonable restrictions on transportation, except if a Minnesota court or agency orders the child placed at a day care and treatment program and the resident district receives a copy of the order, then the resident district must provide transportation to and from the program unless the court or agency orders otherwise. Transportation shall only be provided by the resident district during regular operating hours of the resident district. The resident district may provide the educational program at a school within the district of residence, at the child's residence, or in the district in which the day treatment center is located by paying tuition to that district. If a child's district of residence, district of open enrollment under section 124D.03, or charter school of enrollment under section 124E.11 is authorized to provide online learning instruction under state statutes, the child's district of residence may utilize that online learning program in fulfilling its

educational program responsibility under this section if the child, or the child's parent or guardian for a pupil under the age of 18, agrees to that form of instruction.

(d) When a child is temporarily placed in a residential program for care and treatment, the nonresident district in which the child is placed is responsible for providing an appropriate educational program for the child and necessary transportation while the child is attending the educational program; and must bill the district of the child's residence for the actual cost of providing the program, as outlined in section 125A.11, except as provided in paragraph (e). However, the board, lodging, and treatment costs incurred in behalf of a child with a disability placed outside of the school district of residence by the commissioner of human services; the commissioner of children, youth, and families; or the commissioner of corrections or their agents~~,~~ for reasons other than providing for the child's special educational needs must not become the responsibility of either the district providing the instruction or the district of the child's residence. For the purposes of this section, the state correctional facilities operated on a fee-for-service basis are considered to be residential programs for care and treatment. If a child's district of residence, district of open enrollment under section 124D.03, or charter school of enrollment under section 124E.11 is authorized to provide online learning instruction under state statutes, the nonresident district may utilize that online learning program in fulfilling its educational program responsibility under this section if the child, or the child's parent or guardian for a pupil under the age of 18, agrees to that form of instruction.

(e) A privately owned and operated residential facility may enter into a contract to obtain appropriate educational programs for special education children and services with a joint powers entity. The entity with which the private facility contracts for special education services shall be the district responsible for providing students placed in that facility an appropriate educational program in place of the district in which the facility is located. If a privately owned and operated residential facility does not enter into a contract under this paragraph, then paragraph (d) applies.

(f) The district of residence shall pay tuition and other program costs, not including transportation costs, to the district providing the instruction and services. The district of residence may claim general education aid for the child as provided by law. Transportation costs must be paid by the district responsible for providing the transportation and the state must pay transportation aid to that district.

Sec. 11. Minnesota Statutes 2024, section 125A.744, subdivision 2, is amended to read:

Subd. 2. **Statewide data management system.** The commissioner of education, in cooperation with the ~~commissioner~~ commissioners of human services and children, youth, and families, shall develop a statewide data management system using the educational data reporting system or other existing data management system for school districts and cooperative units to use to maximize medical assistance reimbursement for health and health-related services provided under individualized education programs and individual family service plans. The system must be appropriately integrated with state and local existing and developing human services and education data systems. The statewide data management system must enable school district and cooperative unit staff to:

(1) establish medical assistance billing systems or improve existing systems;

(2) understand the appropriate medical assistance billing codes for services provided under individualized education programs and individual family service plans;

(3) comply with the Individuals with Disabilities Education Act, Public Law 105-17;

(4) contract with billing agents; and

(5) carry out other activities necessary to maximize medical assistance reimbursement.

Sec. 12. Minnesota Statutes 2024, section 127A.11, is amended to read:

127A.11 MONITOR MEDICAL ASSISTANCE SERVICES FOR DISABLED STUDENTS.

The commissioner of education, in cooperation with the ~~commissioner~~ commissioners of human services and children, youth, and families, shall monitor the costs of health-related, special education services provided by public schools.

Sec. 13. Minnesota Statutes 2024, section 127A.70, subdivision 2, is amended to read:

Subd. 2. **Powers and duties; report.** (a) The partnership shall develop recommendations to the governor and the legislature designed to maximize the achievement of all P-20 students while promoting the efficient use of state resources, thereby helping the state realize the maximum value for its investment. These recommendations may include, but are not limited to, strategies, policies, or other actions focused on:

(1) improving the quality of and access to education at all points from preschool through graduate education;

(2) improving preparation for, and transitions to, postsecondary education and work;

(3) ensuring educator quality by creating rigorous standards for teacher recruitment, teacher preparation, induction and mentoring of beginning teachers, and continuous professional development for career teachers; and

(4) realigning the governance and administrative structures of early education, kindergarten through grade 12, and postsecondary systems in Minnesota.

(b) Under the direction of the P-20 Education Partnership Statewide Longitudinal Education Data System Governance Committee, the Office of Higher Education and the Departments of Education; Children, Youth, and Families; and Employment and Economic Development shall improve and expand the Statewide Longitudinal Education Data System (SLEDS) and the Early Childhood Longitudinal Data System (ECLDS) to provide policymakers, education and workforce leaders, researchers, and members of the public with data, research, and reports to:

(1) expand reporting on students' educational outcomes for diverse student populations including at-risk students, children with disabilities, English learners, and gifted students, among others, and include formative and summative evaluations based on multiple measures of child well-being, early childhood development, and student progress toward career and college readiness;

(2) evaluate the effectiveness of early care, educational, and workforce programs; and

(3) evaluate the relationships among early care, education, and workforce outcomes, consistent with section 124D.49.

To the extent possible under federal and state law, research and reports should be accessible to the public on the Internet, and disaggregated by demographic characteristics, organization or organization characteristics, and geography.

It is the intent of the legislature that the Statewide Longitudinal Education Data System and the Early Childhood Longitudinal Data System inform public policy and decision-making. The SLEDS governance committee and ECLDS governance committee, with assistance from staff of the Office of Higher Education; the Department of Education; the Department of Children, Youth, and Families; and the Department of Employment and Economic Development, shall respond to legislative committee and agency requests on topics utilizing data made available through the Statewide Longitudinal Education Data System and the Early Childhood Longitudinal Data System as resources permit. Any analysis of or report on the data must contain only summary data.

(c) By January 15 of each year, the partnership shall submit a report to the governor and to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over P-20 education policy and finance that summarizes the partnership's progress in meeting its goals and identifies the need for any draft legislation when necessary to further the goals of the partnership to maximize student achievement while promoting efficient use of resources.

Sec. 14. Minnesota Statutes 2024, section 142A.607, subdivision 14, is amended to read:

Subd. 14. **Notice for caregiver.** (a) The agency as defined in subdivision 7 or 12 that is responsible for completing the initial assessment or reassessment must provide the child's caregiver with written notice of the initial assessment or reassessment.

(b) Initial assessment notices must be sent within 15 days of completion of the initial assessment and must minimally include the following:

(1) a summary of the child's completed individual assessment used to determine the initial rating;

(2) statement of rating and benefit level;

(3) statement of the circumstances under which the agency must reassess the child;

(4) procedure to seek reassessment;

(5) notice that the caregiver has the right to a fair hearing review of the assessment and how to request a fair hearing, consistent with ~~section~~ sections 142A.20 and 256.045, subdivision 3; and

(6) the name, telephone number, and email, if available, of a contact person at the agency completing the assessment.

(c) Reassessment notices must be sent within 15 days after the completion of the reassessment and must minimally include the following:

(1) a summary of the child's individual assessment used to determine the new rating;

(2) any change in rating and its effective date;

(3) procedure to seek reassessment;

(4) notice that if a change in rating results in a reduction of benefits, the caregiver has the right to a fair hearing review of the assessment and how to request a fair hearing consistent with ~~section~~ sections 142A.20 and 256.045, subdivision 3;

(5) notice that a caregiver who requests a fair hearing of the reassessed rating within ten days may continue at the current rate pending the hearing, but the agency may recover any overpayment; and

(6) name, telephone number, and email, if available, of a contact person at the agency completing the reassessment.

(d) Notice is not required for special assessments since the notice is part of the Northstar kinship assistance or adoption assistance negotiated agreement completed according to section 142A.608.

Sec. 15. Minnesota Statutes 2024, section 142A.609, subdivision 21, is amended to read:

Subd. 21. **Termination notice for caregiver or youth.** The agency that issues the maintenance payment shall provide the child's caregiver or the youth with written notice of termination of payment. Termination notices must be sent at least 15 days before the final payment or, in the case of an unplanned termination, the notice is sent within three days of the end of the payment. The written notice must minimally include the following:

(1) the date payment will end;

(2) the reason payments will end and the event that is the basis to terminate payment;

(3) a statement that the caregiver or youth has a right to a fair hearing review by the department consistent with ~~section~~ sections 142A.20 and 256.045, subdivision 3;

(4) the procedure to request a fair hearing; and

(5) the name, telephone number, and email address of a contact person at the agency.

Sec. 16. Minnesota Statutes 2024, section 142B.41, subdivision 9, is amended to read:

Subd. 9. **Swimming pools; family day care and group family day care providers.** (a) This subdivision governs swimming pools located at family day care or group family day care homes licensed under Minnesota Rules, chapter 9502. This subdivision does not apply to portable wading pools or whirlpools located at family day care or group family day care homes licensed under Minnesota Rules, chapter 9502. For a provider to be eligible to allow a child cared for at the family day care or group family day care home to use the swimming pool located at the home, the provider must not have had a licensing sanction under section 142B.18 or 245A.07 or a correction order or conditional license under section 142B.16 or 245A.06 relating to the supervision or health and safety of children during the prior 24 months, and must satisfy the following requirements:

(1) notify the county agency before initial use of the swimming pool and annually, thereafter;

(2) obtain written consent from a child's parent or legal guardian allowing the child to use the swimming pool and renew the parent or legal guardian's written consent at least annually. The written consent must include a statement that the parent or legal guardian has received and read materials provided by the Department of Health to the Department of Children, Youth, and Families for distribution to all family day care or group family day care homes and the general public on the human services Internet website related to the risk of disease transmission as well as other health risks associated with swimming pools. The written consent must also include a statement that the Department of Health, Department of Children, Youth, and Families, and county agency will not monitor or inspect the provider's swimming pool to ensure compliance with the requirements in this subdivision;

(3) enter into a written contract with a child's parent or legal guardian and renew the written contract annually. The terms of the written contract must specify that the provider agrees to perform all of the requirements in this subdivision;

(4) attend and successfully complete a swimming pool operator training course once every five years. Acceptable training courses are:

(i) the National Swimming Pool Foundation Certified Pool Operator course;

(ii) the National Spa and Pool Institute Tech I and Tech II courses (both required); or

(iii) the National Recreation and Park Association Aquatic Facility Operator course;

(5) require a caregiver trained in first aid and adult and child cardiopulmonary resuscitation to supervise and be present at the swimming pool with any children in the pool;

(6) toilet all potty-trained children before they enter the swimming pool;

(7) require all children who are not potty-trained to wear swim diapers while in the swimming pool;

(8) if fecal material enters the swimming pool water, add three times the normal shock treatment to the pool water to raise the chlorine level to at least 20 parts per million, and close the pool to swimming for the 24 hours following the entrance of fecal material into the water or until the water pH and disinfectant concentration levels have returned to the standards specified in clause (10), whichever is later;

(9) prevent any person from entering the swimming pool who has an open wound or any person who has or is suspected of having a communicable disease;

(10) maintain the swimming pool water at a pH of not less than 7.2 and not more than 8.0, maintain the disinfectant concentration between two and five parts per million for chlorine or between 2.3 and 4.5 parts per million for bromine, and maintain a daily record of the swimming pool's operation with pH and disinfectant concentration readings on days when children cared for at the family day care or group family day care home are present;

(11) have a disinfectant feeder or feeders;

(12) have a recirculation system that will clarify and disinfect the swimming pool volume of water in ten hours or less;

(13) maintain the swimming pool's water clarity so that an object on the pool floor at the pool's deepest point is easily visible;

(14) comply with the provisions of the Abigail Taylor Pool Safety Act in section 144.1222, subdivisions 1c and 1d;

(15) have in place and enforce written safety rules and swimming pool policies;

(16) have in place at all times a safety rope that divides the shallow and deep portions of the swimming pool;

(17) satisfy any existing local ordinances regarding swimming pool installation, decks, and fencing;

(18) maintain a water temperature of not more than 104 degrees Fahrenheit and not less than 70 degrees Fahrenheit; and

(19) for lifesaving equipment, have a United States Coast Guard-approved life ring attached to a rope, an exit ladder, and a shepherd's hook available at all times to the caregiver supervising the swimming pool.

The requirements of clauses (5), (16), and (18) only apply at times when children cared for at the family day care or group family day care home are present.

(b) A violation of paragraph (a), clauses (1) to (3), is grounds for a sanction under section 142B.18 or a correction order or conditional license under section 142B.16.

(c) If a provider under this subdivision receives a licensing sanction under section 142B.18 or 245A.07 or a correction order or a conditional license under section 142B.16 or 245A.06 relating to the supervision or health and safety of children, the provider is

prohibited from allowing a child cared for at the family day care or group family day care home to continue to use the swimming pool located at the home.

Sec. 17. Minnesota Statutes 2024, section 144.061, is amended to read:

144.061 EARLY DENTAL PREVENTION INITIATIVE.

(a) The commissioner of health, in collaboration with the ~~commissioner~~ commissioners of human services and children, youth, and families, shall implement a statewide initiative to increase awareness among communities of color and recent immigrants on the importance of early preventive dental intervention for infants and toddlers before and after primary teeth appear.

(b) The commissioner shall develop educational materials and information for expectant and new parents within the targeted communities that include the importance of early dental care to prevent early cavities, including proper cleaning techniques and feeding habits, before and after primary teeth appear.

(c) The commissioner shall develop a distribution plan to ensure that the materials are distributed to expectant and new parents within the targeted communities, including, but not limited to, making the materials available to health care providers, community clinics, WIC sites, and other relevant sites within the targeted communities.

(d) In developing these materials and distribution plan, the commissioner shall work collaboratively with members of the targeted communities, dental providers, pediatricians, child care providers, and home visiting nurses.

(e) The commissioner shall, with input from stakeholders listed in paragraph (d), develop and pilot incentives to encourage early dental care within one year of an infant's teeth erupting.

Sec. 18. Minnesota Statutes 2024, section 144.225, subdivision 2a, is amended to read:

Subd. 2a. **Health data associated with birth registration.** (a) Information from which an identification of risk for disease, disability, or developmental delay in a mother or child can be made, that is collected in conjunction with birth registration or fetal death reporting, is private data as defined in section 13.02, subdivision 12.

(b) The commissioner may disclose to a tribal health department or community health board, as defined in section 145A.02, subdivision 5, health data associated with birth registration which identifies a mother or child at high risk for serious disease, disability, or

developmental delay in order to assure access to appropriate health, social, or educational services.

(c) Notwithstanding the designation of the private data, the commissioner of human services shall have access to health data associated with birth registration for:

(1) purposes of administering medical assistance and the MinnesotaCare program; and

(2) for other public health purposes as determined by the commissioner of health.

(d) Notwithstanding the designation of the private data, the commissioner of children, youth, and families shall have access to health data associated with birth registration for other public health purposes as determined by the commissioner of health.

Sec. 19. Minnesota Statutes 2024, section 145.895, is amended to read:

145.895 DEPARTMENT OF HUMAN SERVICES.

The commissioner of human services shall cooperate with the ~~commissioner~~ commissioners of health and children, youth, and families in identifying eligible individuals. The commissioner of human services shall provide a procedure for the notification of pregnant or lactating women, infants and children receiving any form of public assistance of eligibility for benefits under this program.

Sec. 20. Minnesota Statutes 2024, section 145.901, subdivision 2, is amended to read:

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (c), without the consent of the subject of the data, and without the consent of the parent, spouse, other guardian, or legal representative of the subject of the data, when the subject of the data is a woman who died during a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a pregnancy.

The commissioner has access only to medical data and health records related to deaths that occur on or after July 1, 2000, including the names of the providers, clinics, or other health services such as family home visiting programs; the women, infants, and children (WIC) program; prescription monitoring programs; and behavioral health services, where care was received before, during, or related to the pregnancy or death. The commissioner has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital discharge data, for the purpose of providing the name and location of any pre-pregnancy,

prenatal, or other care received by the subject of the data up to one year after the end of the pregnancy.

(b) The provider or responsible authority that creates, maintains, or stores the data shall furnish the data upon the request of the commissioner. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) The commissioner shall make a good faith reasonable effort to notify the parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the parent, spouse, guardian, or legal representative informing the recipient of the data collection and offering a public health nurse support visit if desired.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner may request and receive from a coroner or medical examiner the name of the health care provider that provided prenatal, postpartum, or other health services to the subject of the data.

(f) The commissioner may access Department of Human Services and Department of Children, Youth, and Families data to identify sources of care and services to assist with the evaluation of welfare systems, including housing, to reduce preventable maternal deaths.

(g) The commissioner may request and receive law enforcement reports or incident reports related to the subject of the data.

Sec. 21. Minnesota Statutes 2024, section 145.901, subdivision 4, is amended to read:

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery

or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out maternal death studies.

(c) Summary data on maternal death studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services or the commissioner of children, youth, and families to the commissioner of health under this section retain the same classification the data held when retained by the commissioner of human services or the commissioner of children, youth, and families, as required under section 13.03, subdivision 4, paragraph (c).

Sec. 22. Minnesota Statutes 2024, section 145.9255, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** To the extent funds are available for the purposes of this subdivision, the commissioner of health, in consultation with a representative from Minnesota planning~~,~~; the commissioner of human services~~,~~; the commissioner of children, youth, and families; and the commissioner of education, shall develop and implement the Minnesota education now and babies later (MN ENABL) program, targeted to adolescents ages 12 to 14, with the goal of reducing the incidence of adolescent pregnancy in the state and promoting abstinence until marriage. The program must provide a multifaceted, primary prevention, community health promotion approach to educating and supporting adolescents in the decision to postpone sexual involvement modeled after the ENABL program in California. The commissioner of health shall consult with the chief of the health education section of the California Department of Health Services for general guidance in developing and implementing the program.

Sec. 23. Minnesota Statutes 2024, section 145.9265, is amended to read:

145.9265 FETAL ALCOHOL SYNDROME EFFECTS; DRUG-EXPOSED INFANT.

The commissioner of health, in coordination with the commissioner of education; the commissioner of children, youth, and families; and the commissioner of human services, shall design and implement a coordinated prevention effort to reduce the rates of fetal alcohol syndrome and fetal alcohol effects, and reduce the number of drug-exposed infants. The commissioner shall:

(1) conduct research to determine the most effective methods of preventing fetal alcohol syndrome, fetal alcohol effects, and drug-exposed infants and to determine the best methods for collecting information on the incidence and prevalence of these problems in Minnesota;

(2) provide training on effective prevention methods to health care professionals and human services workers; and

(3) operate a statewide media campaign focused on reducing the incidence of fetal alcohol syndrome and fetal alcohol effects~~,~~ and reducing the number of drug-exposed infants.

Sec. 24. Minnesota Statutes 2024, section 174.285, subdivision 4, is amended to read:

Subd. 4. **Membership.** (a) The council is composed of the following ~~13~~ 14 members:

(1) one representative from the Office of the Governor;

(2) one representative from the Council on Disability;

(3) one representative from the Minnesota Public Transit Association;

(4) the commissioner of transportation or a designee;

(5) the commissioner of human services or a designee;

(6) the commissioner of health or a designee;

(7) the chair of the Metropolitan Council or a designee;

(8) the commissioner of education or a designee;

(9) the commissioner of veterans affairs or a designee;

(10) one representative from the Board on Aging;

(11) the commissioner of employment and economic development or a designee;

(12) the commissioner of commerce or a designee; ~~and~~

(13) the commissioner of management and budget or a designee~~.~~; and

(14) the commissioner of children, youth, and families or a designee.

(b) All appointments required by paragraph (a) must be completed by August 1, 2010.

(c) The commissioner of transportation or a designee shall convene the first meeting of the council within two weeks after the members have been appointed to the council. The members shall elect a chair from their membership at the first meeting.

(d) The Department of Transportation and the Department of Human Services shall provide necessary staff support for the council.

Sec. 25. Minnesota Statutes 2024, section 214.104, is amended to read:

214.104 HEALTH-RELATED LICENSING BOARDS; SUBSTANTIATED MALTREATMENT.

(a) A health-related licensing board shall make determinations as to whether regulated persons who are under the board's jurisdiction should be the subject of disciplinary or corrective action because of substantiated maltreatment under section 626.557 or chapter 260E. The board shall make a determination upon receipt, and after the review, of an investigation memorandum or other notice of substantiated maltreatment under section 626.557~~,~~ or chapter 260E~~,~~ or of a notice from the commissioner of human services or the commissioner of children, youth, and families that a background study of a regulated person shows substantiated maltreatment.

(b) Upon completion of its review of a report of substantiated maltreatment, the board shall notify the ~~commissioner~~ commissioners of human services and children, youth, and families of its determination. The board shall notify the commissioner of human services if, following a review of the report of substantiated maltreatment, the board determines that it does not have jurisdiction in the matter and the commissioner shall make the appropriate disqualification decision regarding the regulated person as otherwise provided in chapter 245C. The board shall also notify the commissioner of health ~~or~~; the commissioner of human services; or the commissioner of children, youth, and families immediately upon receipt of knowledge of a facility or program allowing a regulated person to provide direct contact services at the facility or program while not complying with requirements placed on the regulated person.

(c) In addition to any other remedy provided by law, the board may, through its designated board member, temporarily suspend the license of a licensee; deny a credential to an applicant; or require the regulated person to be continuously supervised, if the board finds there is probable cause to believe the regulated person referred to the board according to paragraph (a) poses an immediate risk of harm to vulnerable persons. The board shall consider all relevant information available, which may include but is not limited to:

(1) the extent the action is needed to protect persons receiving services or the public;

(2) the recency of the maltreatment;

(3) the number of incidents of maltreatment;

(4) the intrusiveness or violence of the maltreatment; and

(5) the vulnerability of the victim of maltreatment.

The action shall take effect upon written notice to the regulated person, served by certified mail, specifying the statute violated. The board shall notify the commissioner of health ~~or~~; the commissioner of human services; or the commissioner of children, youth, and families of the suspension or denial of a credential. The action shall remain in effect until the board issues a temporary stay or a final order in the matter after a hearing or upon agreement between the board and the regulated person. At the time the board issues the notice, the regulated person shall inform the board of all settings in which the regulated person is employed or practices. The board shall inform all known employment and practice settings of the board action and schedule a disciplinary hearing to be held under chapter 14. The board shall provide the regulated person with at least 30 days' notice of the hearing, unless the parties agree to a hearing date that provides less than 30 days' notice, and shall schedule the hearing to begin no later than 90 days after issuance of the notice of hearing.

Sec. 26. Minnesota Statutes 2024, section 216C.266, subdivision 2, is amended to read:

Subd. 2. **Sharing energy assistance program data.** The commissioner may disseminate to the ~~commissioner~~ commissioners of human services and children, youth, and families the name, telephone number, and last four digits of the Social Security number of any individual who applies on behalf of a household for benefits or services provided by the energy assistance program if the household is determined to be eligible for the energy assistance program.

Sec. 27. Minnesota Statutes 2024, section 216C.266, subdivision 3, is amended to read:

Subd. 3. **Use of shared data.** Data disseminated to the ~~commissioner~~ commissioners of human services and children, youth, and families under subdivision 2 may be disclosed to a person other than the subject of the data only for the purpose of determining a household's eligibility for the telephone assistance program pursuant to section 13.46, subdivision 2, clause (23).

Sec. 28. Minnesota Statutes 2024, section 241.021, subdivision 2, is amended to read:

Subd. 2. **Facilities for delinquent children and youth; licenses; supervision.** Notwithstanding any provisions in sections 256.01, subdivision 2, paragraph (a), clause (2)~~,~~; 142B.05; 142B.10; 245A.03~~,~~; and 245A.04~~,~~ and chapter 245C~~,~~ to the contrary, but subject to the municipality notification requirements of subdivision 2a, the commissioner of corrections shall review all county, municipal, or other publicly established and operated facilities for the detention, care and training of delinquent children and youth at least once every biennium, and if such facility conforms to reasonable standards established by the

commissioner or in the commissioner's judgment is making satisfactory progress toward substantial conformity therewith, and the commissioner is satisfied that the interests and well-being of children and youth received therein are protected, the commissioner shall grant a license to the county, municipality or agency thereof operating such facility. The commissioner may grant licensure up to two years. Each such facility shall cooperate with the commissioner to make available all facts regarding its operation and services as the commissioner requires to determine its conformance to standards and its competence to give the services needed and which it purports to give. Every such facility as herein described is subject to visitation and supervision by the commissioner and shall receive from the commissioner consultation as needed to strengthen services to the children and youth received therein.

Sec. 29. Minnesota Statutes 2024, section 242.09, is amended to read:

242.09 COOPERATION; OTHER AGENCIES.

The commissioner of human services~~,~~; the commissioner of education~~,~~; the commissioner of children, youth, and families; and the ~~state~~ commissioner of health shall advise, cooperate with and assist the commissioner of corrections in carrying out the duties and responsibilities assigned by this chapter, and for these purposes may attend meetings. Their facilities and services and those of other state agencies, particularly of the Department of Human Services and Department of Children, Youth, and Families, shall be made available to the commissioner of corrections upon the terms the governor directs.

Sec. 30. Minnesota Statutes 2024, section 242.21, is amended to read:

242.21 COOPERATION; STATE INSTITUTIONS, LOCAL POLICE OFFICERS.

The commissioner of corrections may enter into agreement with the Direct Care and Treatment executive board~~, with~~; the commissioner of children, youth, and families; the commissioner of human services; local probation officers or other public officials; and ~~with~~ public or private agencies, schools, or institutions~~,~~ for custody, separate care, special treatment, training, or diagnostic services of persons committed to the care or subject to the control of the commissioner of corrections. The commissioner of corrections may pay any costs incurred by such agreements to the extent that funds for such purposes are made available to the commissioner by the legislature.

Sec. 31. Minnesota Statutes 2024, section 242.32, subdivision 1, is amended to read:

Subdivision 1. **Community-based programming.** The commissioner of corrections shall be charged with the duty of developing constructive programs for the prevention and decrease of delinquency and crime among youth. To that end, the commissioner shall cooperate with counties and existing agencies to encourage the establishment of new programming, both local and statewide, to provide a continuum of services for serious and repeat juvenile offenders who do not require secure placement. The commissioner shall work jointly with the commissioner of human services; the commissioner of children, youth, and families; and counties and municipalities to develop and provide community-based services for residential placement of juvenile offenders and community-based services for nonresidential programming for juvenile offenders and their families.

Notwithstanding any law to the contrary, the commissioner of corrections is authorized to contract with counties placing juveniles in the serious/chronic program at the Minnesota Correctional Facility-Red Wing to provide necessary extended community transition programming. Funds resulting from the contracts shall be deposited in the state treasury and are appropriated to the commissioner for juvenile correctional purposes.

Sec. 32. Minnesota Statutes 2024, section 245.697, subdivision 1, is amended to read:

Subdivision 1. **Creation.** (a) A State Advisory Council on Mental Health is created. The council must have members appointed by the governor in accordance with federal requirements. In making the appointments, the governor shall consider appropriate representation of communities of color. The council must be composed of:

(1) the assistant commissioner of the Department of Human Services who oversees behavioral health policy;

(2) a representative of the Department of Human Services responsible for the medical assistance program;

(3) a representative of Direct Care and Treatment;

(4) a representative of the Department of Health;

(5) a representative of the Department of Children, Youth, and Families;

~~(5)~~ (6) one member of each of the following professions:

(i) psychiatry;

(ii) psychology;

(iii) social work;

(iv) nursing;

(v) marriage and family therapy; and

(vi) professional clinical counseling;

~~(6)~~ (7) one representative from each of the following advocacy groups: Mental Health Association of Minnesota, NAMI-MN, Minnesota Disability Law Center, American Indian Mental Health Advisory Council, and a consumer-run mental health advocacy group;

~~(7)~~ (8) providers of mental health services;

~~(8)~~ (9) consumers of mental health services;

~~(9)~~ (10) family members of persons with mental illnesses;

~~(10)~~ (11) legislators;

~~(11)~~ (12) social service agency directors;

~~(12)~~ (13) county commissioners; and

~~(13)~~ (14) other members reflecting a broad range of community interests, including family physicians, or members as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.

(b) The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. Notwithstanding provisions of section 15.059, the council and its subcommittee on children's mental health do not expire. The commissioner of human services shall provide staff support and supplies to the council.

Sec. 33. Minnesota Statutes 2024, section 245.697, subdivision 2a, is amended to read:

Subd. 2a. **Subcommittee on Children's Mental Health.** The State Advisory Council on Mental Health (the "advisory council") must have a Subcommittee on Children's Mental Health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

(1) the commissioners or designees of the commissioners of the Departments of Human Services~~,~~; Children, Youth, and Families; Health~~,~~; Education~~,~~; State Planning~~,~~; and Corrections;

(2) a designee of the Direct Care and Treatment executive board;

(3) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;

(4) at least one representative of an advocacy group for children with emotional disturbances;

(5) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;

(6) parents of children who have emotional disturbances;

(7) a present or former consumer of adolescent mental health services;

(8) educators currently working with emotionally disturbed children;

(9) people knowledgeable about the needs of emotionally disturbed children of minority races and cultures;

(10) people experienced in working with emotionally disturbed children who have committed status offenses;

(11) members of the advisory council;

(12) one person from the local corrections department and one representative of the Minnesota District Judges Association Juvenile Committee; and

(13) county commissioners and social services agency representatives.

The chair of the advisory council shall appoint subcommittee members described in clauses (4) to (12) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance on the subcommittee. Terms, compensation, removal, and filling of vacancies are governed by subdivision 1, except that terms of subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Sec. 34. Minnesota Statutes 2024, section 245.814, subdivision 1, is amended to read:

Subdivision 1. **Insurance for foster home providers.** (a) The commissioner of human services or the commissioner of children, youth, and families shall within the appropriation provided purchase and provide insurance to individuals licensed as foster home providers to cover their liability for:

(1) injuries or property damage caused or sustained by persons in foster care in their home; and

(2) actions arising out of alienation of affections sustained by the birth parents of a foster child or birth parents or children of a foster adult.

(b) Each commissioner shall provide insurance for the providers the commissioner licenses.

(c) For purposes of this subdivision, insurance for homes licensed to provide adult foster care shall be limited to family adult foster care homes as defined in section 245A.02, subdivision 6f, and family adult day services licensed under section 245A.143.

Sec. 35. Minnesota Statutes 2024, section 245.814, subdivision 2, is amended to read:

Subd. 2. **Application of coverage.** Coverage shall apply to all foster homes licensed by the Department of Human Services or the Department of Children, Youth, and Families, licensed by a federally recognized tribal government, or established by the juvenile court and certified by the commissioner of corrections pursuant to section 260B.198, subdivision 1, paragraph (a), clause (3), item (v), to the extent that the liability is not covered by the provisions of the standard homeowner's or automobile insurance policy. The insurance shall not cover property owned by the individual foster home provider, damage caused intentionally by a person over 12 years of age, or property damage arising out of business pursuits or the operation of any vehicle, machinery, or equipment.

Sec. 36. Minnesota Statutes 2024, section 245.814, subdivision 3, is amended to read:

Subd. 3. **Compensation provisions.** If the commissioner of human services or the commissioner of children, youth, and families is unable to obtain insurance through ordinary methods for coverage of foster home providers, the appropriation shall be returned to the general fund and the state shall pay claims subject to the following limitations.

(a) Compensation shall be provided only for injuries, damage, or actions set forth in subdivision 1.

(b) Compensation shall be subject to the conditions and exclusions set forth in subdivision 2.

(c) The state shall provide compensation for bodily injury, property damage, or personal injury resulting from the foster home providers activities as a foster home provider while the foster child or adult is in the care, custody, and control of the foster home provider in an amount not to exceed $250,000 for each occurrence.

(d) The state shall provide compensation for damage or destruction of property caused or sustained by a foster child or adult in an amount not to exceed $250 for each occurrence.

(e) The compensation in paragraphs (c) and (d) is the total obligation for all damages because of each occurrence regardless of the number of claims made in connection with the same occurrence, but compensation applies separately to each foster home. The state shall have no other responsibility to provide compensation for any injury or loss caused or sustained by any foster home provider or foster child or foster adult.

This coverage is extended as a benefit to foster home providers to encourage care of persons who need out-of-home care. Nothing in this section shall be construed to mean that foster home providers are agents or employees of the state nor does the state accept any responsibility for the selection, monitoring, supervision, or control of foster home providers which is exclusively the responsibility of the counties which shall regulate foster home providers in the manner set forth in the rules of the ~~commissioner~~ commissioners of human services and children, youth, and families.

Sec. 37. Minnesota Statutes 2024, section 245.814, subdivision 4, is amended to read:

Subd. 4. **Liability insurance; risk pool.** If the commissioner that licenses a program determines that appropriate commercial liability insurance coverage is not available for a licensed foster home, group home, developmental achievement center, or day care provider, and that coverage available through the joint underwriting authority of the commissioner of commerce or other public entity is not appropriate for the provider or a class of providers, the commissioner of human services; the commissioner of children, youth, and families; and the commissioner of commerce may jointly establish a risk pool to provide coverage for licensed providers out of premiums or fees paid by providers. The commissioners may set limits on coverage, establish premiums or fees, determine the proportionate share of each provider to be collected in a premium or fee based on the provider's claim experience and other factors the commissioners consider appropriate, establish eligibility and application requirements for coverage, and take other action necessary to accomplish the purposes of this subdivision. A human services risk pool fund is created for the purposes of this subdivision. Fees and premiums collected from providers for risk pool coverage are appropriated to the risk pool fund. Interest earned from the investment of money in the fund must be credited to the fund and money in the fund is appropriated to the ~~commissioner~~ commissioners of human services and children, youth, and families in proportion to the amounts insured by each commissioner to pay administrative costs and covered claims for participating providers. In the event that money in the fund is insufficient to pay outstanding

claims and associated administrative costs, the ~~commissioner~~ commissioners of human services and children, youth, and families may assess providers participating in the risk pool amounts sufficient to pay the costs. The ~~commissioner~~ commissioners of human services and children, youth, and families may not assess a provider an amount exceeding one year's premiums collected from that provider.

Sec. 38. Minnesota Statutes 2024, section 245C.02, subdivision 7, is amended to read:

Subd. 7. **Commissioner.** "Commissioner" ~~has the meaning given in section 245A.02, subdivision 5~~ means the commissioner of human services.

Sec. 39. Minnesota Statutes 2024, section 245C.02, subdivision 12, is amended to read:

Subd. 12. **License.** "License" ~~has the meaning given in section 245A.02, subdivision 8~~ means a certificate issued by the commissioner of human services; children, youth, and families; corrections; or health authorizing the license holder to provide a specified program for a specified period of time and in accordance with the terms of the license and the rules of the commissioner issuing the license.

Sec. 40. Minnesota Statutes 2024, section 245C.02, subdivision 13, is amended to read:

Subd. 13. **License holder.** "License holder" ~~has the meaning given in section 245A.02, subdivision 9~~ means an individual, organization, or government entity that is legally responsible for the operation of the program or service and has been granted a license by the commissioner of human services; children, youth, and families; corrections; or health.

Sec. 41. Minnesota Statutes 2024, section 245C.031, subdivision 9, is amended to read:

Subd. 9. **Guardians ad litem; required checks.** (a) An alternative background study for a guardian ad litem under subdivision 8 must include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data obtained by the commissioner of human services; and

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a minor or a vulnerable adult. If the study subject has been determined by the Department of Human Services; the Department of Children, Youth, and Families; or the Department of Health to be the perpetrator of substantiated maltreatment of a minor or a vulnerable adult in a licensed facility, the response must include a copy of the public portion of the investigation memorandum under section 260E.30 or the public portion of the investigation memorandum under section 626.557, subdivision 12b. When the background study shows

that the subject has been determined by a county adult protection or child protection agency to have been responsible for maltreatment, the court shall be informed of the county, the date of the finding, and the nature of the maltreatment that was substantiated.

(b) For checks of records under paragraph (a), clauses (1) and (2), the commissioner shall provide the records within 15 working days of receiving the request. The information obtained under sections 245C.05 and 245C.08 from a national criminal history records check shall be provided within three working days of the commissioner's receipt of the data.

(c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner or county lead agency or lead investigative agency has information that a person of whom a background study was previously completed under this section has been determined to be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the county may provide this information to the court that requested the background study.

Sec. 42. Minnesota Statutes 2024, section 245C.033, subdivision 2, is amended to read:

Subd. 2. **State licensing agency data.** (a) Requests for state licensing agency data submitted pursuant to section 524.5-118 must include information from a check of state licensing agency records.

(b) The commissioner shall provide the court with licensing agency data for licenses directly related to the responsibilities of a guardian or conservator if the guardian or conservator has a current or prior affiliation with the:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

(3) Board of Social Work;

(4) Board of Psychology;

(5) Board of Nursing;

(6) Board of Medical Practice;

(7) Department of Education;

(8) Department of Commerce;

(9) Board of Chiropractic Examiners;

(10) Board of Dentistry;

(11) Board of Marriage and Family Therapy;

(12) Department of Human Services;

(13) Department of Children, Youth, and Families;

~~(13)~~ (14) Peace Officer Standards and Training (POST) Board; or

~~(14)~~ (15) Professional Educator Licensing and Standards Board.

(c) The commissioner shall provide to the court the electronically available data maintained in the agency's database, including whether the guardian or conservator is or has been licensed by the agency and whether a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation, is in the licensing agency's database.

Sec. 43. Minnesota Statutes 2024, section 245C.05, subdivision 7, is amended to read:

Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or corrections agent shall notify the commissioner of an individual's conviction if the individual:

(1) has been affiliated with a program or facility regulated by the Department of Human Services; Department of Children, Youth, and Families; or Department of Health, a facility serving children or youth licensed by the Department of Corrections, or any type of home care agency or provider of personal care assistance services within the preceding year; and

(2) has been convicted of a crime constituting a disqualification under section 245C.14.

(b) For the purpose of this subdivision, "conviction" has the meaning given it in section 609.02, subdivision 5.

(c) The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this subdivision and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents.

(d) The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes shall be reported to the commissioner by the corrections system.

(e) A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this subdivision.

(f) Upon receipt of disqualifying information, the commissioner shall provide the notice required under section 245C.17, as appropriate, to agencies on record as having initiated a

background study or making a request for documentation of the background study status of the individual.

(g) This subdivision does not apply to family child care programs or legal nonlicensed child care programs for individuals whose background study was completed in NETStudy 2.0.

Sec. 44. Minnesota Statutes 2024, section 245C.07, is amended to read:

245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.

(a) Subject to the conditions in paragraph (d), when a license holder, applicant, or other entity owns multiple programs or services that are licensed by the Department of Human Services~~,~~; Department of Children, Youth, and Families; Department of Health~~,~~; or Department of Corrections, only one background study is required for an individual who provides direct contact services in one or more of the licensed programs or services if:

(1) the license holder designates one individual with one address and telephone number as the person to receive sensitive background study information for the multiple licensed programs or services that depend on the same background study; and

(2) the individual designated to receive the sensitive background study information is capable of determining, upon request of the department, whether a background study subject is providing direct contact services in one or more of the license holder's programs or services and, if so, at which location or locations.

(b) When a license holder maintains background study compliance for multiple licensed programs according to paragraph (a), and one or more of the licensed programs closes, the license holder shall immediately notify the commissioner which staff must be transferred to an active license so that the background studies can be electronically paired with the license holder's active program.

(c) When a background study is being initiated by a licensed program or service or a foster care provider that is also licensed under chapter 144G, a study subject affiliated with multiple licensed programs or services may attach to the background study form a cover letter indicating the additional names of the programs or services, addresses, and background study identification numbers.

When the commissioner receives a notice, the commissioner shall notify each program or service identified by the background study subject of the study results.

The background study notice the commissioner sends to the subsequent agencies shall satisfy those programs' or services' responsibilities for initiating a background study on that individual.

(d) If a background study was conducted on an individual related to child foster care and the requirements under paragraph (a) are met, the background study is transferable across all licensed programs. If a background study was conducted on an individual under a license other than child foster care and the requirements under paragraph (a) are met, the background study is transferable to all licensed programs except child foster care.

(e) The provisions of this section that allow a single background study in one or more licensed programs or services do not apply to background studies submitted by adoption agencies, supplemental nursing services agencies, personnel pool agencies, educational programs, professional services agencies, temporary personnel agencies, and unlicensed personal care provider organizations.

(f) For an entity operating under NETStudy 2.0, the entity's active roster must be the system used to document when a background study subject is affiliated with multiple entities. For a background study to be transferable:

(1) the background study subject must be on and moving to a roster for which the person designated to receive sensitive background study information is the same; and

(2) the same entity must own or legally control both the roster from which the transfer is occurring and the roster to which the transfer is occurring. For an entity that holds or controls multiple licenses, or unlicensed personal care provider organizations, there must be a common highest level entity that has a legally identifiable structure that can be verified through records available from the secretary of state.

Sec. 45. Minnesota Statutes 2024, section 256.88, is amended to read:

256.88 SOCIAL WELFARE FUND ESTABLISHED.

Except as otherwise expressly provided, all moneys and funds held by the commissioner of human services~~,~~; the commissioner of children, youth, and families; the Direct Care and Treatment executive board~~,~~; and the local social services agencies of the several counties in trust or for the benefit of children with a disability and children who are dependent, neglected, or delinquent~~,~~; children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children~~,~~; persons determined to have developmental disability, mental illness, or substance use disorder~~,~~; or other wards or beneficiaries, under any law, shall be kept in a single fund to be known as the "social

welfare fund" which shall be deposited at interest, held, or disbursed as provided in sections 256.89 to 256.92.

Sec. 46. Minnesota Statutes 2024, section 256.89, is amended to read:

256.89 FUND DEPOSITED IN STATE TREASURY.

The social welfare fund and all accretions thereto shall be deposited in the state treasury, as a separate and distinct fund, to the credit of the commissioner of human services; the commissioner of children, youth, and families; and the Direct Care and Treatment executive board as trustees for their respective beneficiaries in proportion to the beneficiaries' several interests. The commissioner of management and budget shall be responsible only to the commissioner of human services; the commissioner of children, youth, and families; and the Direct Care and Treatment executive board for the sum total of the fund, and shall have no duties nor direct obligations toward the beneficiaries thereof individually. Subject to the applicable rules of the commissioner of human services; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board, money so received by a local social services agency may be deposited by the executive secretary of the local social services agency in a local bank carrying federal deposit insurance, designated by the local social services agency for this purpose. The amount of such deposit in each such bank at any one time shall not exceed the amount protected by federal deposit insurance.

Sec. 47. Minnesota Statutes 2024, section 256.90, is amended to read:

256.90 SOCIAL WELFARE FUND; USE; DISPOSITION; DEPOSITORIES.

The commissioner of human services, in consultation with the commissioner of children, youth, and families and the Direct Care and Treatment executive board, at least 30 days before the first day of January and the first day of July in each year shall file with the commissioner of management and budget an estimate of the amount of the social welfare fund to be held in the treasury during the succeeding six-month period, subject to current disbursement. Such portion of the remainder thereof as may be at any time designated by the request of the commissioner of human services may be invested by the commissioner of management and budget in bonds in which the permanent trust funds of the state of Minnesota may be invested, upon approval by the State Board of Investment. The portion of such remainder not so invested shall be placed by the commissioner of management and budget at interest for the period of six months, or when directed by the commissioner of human services, for the period of 12 months thereafter at the highest rate of interest obtainable in a bank, or banks, designated by the board of deposit as a suitable depository therefor. All

the provisions of law relative to the designation and qualification of depositories of other state funds shall be applicable to sections 256.88 to 256.92, except as herein otherwise provided. Any bond given, or collateral assigned or both, to secure a deposit hereunder may be continuous in character to provide for the repayment of any moneys belonging to the fund theretofore or thereafter at any time deposited in such bank until its designation as such depository is revoked and the security thereof shall be not impaired by any subsequent agreement or understanding as to the rate of interest to be paid upon such deposit, or as to time for its repayment. The amount of money belonging to the fund deposited in any bank, including other state deposits, shall not at any time exceed the amount of the capital stock thereof. In the event of the closing of the bank any sum deposited therein shall immediately become due and payable.

Sec. 48. Minnesota Statutes 2024, section 256.91, is amended to read:

256.91 PURPOSES.

From that part of the social welfare fund held in the state treasury subject to disbursement as provided in section 256.90, the commissioner of human services; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board at any time may pay out such amounts as the ~~commissioner~~ commissioners or executive board deems proper for the support, maintenance, or other legal benefit of any of the children with a disability and children who are dependent, neglected, or delinquent~~,~~; children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children~~,~~; persons with developmental disability, substance use disorder, or mental illness~~,~~; or other wards or persons entitled thereto, not exceeding in the aggregate to or for any person the principal amount previously received for the benefit of the person, together with the increase in it from an equitable apportionment of interest realized from the social welfare fund.

When any such person dies or is finally discharged from the guardianship, care, custody, and control of the commissioner of human services; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board, the amount then remaining subject to use for the benefit of the person shall be paid as soon as may be from the social welfare fund to the persons thereto entitled by law.

Sec. 49. Minnesota Statutes 2024, section 256.92, is amended to read:

256.92 ~~COMMISSIONER OF HUMAN SERVICES AND DIRECT CARE AND TREATMENT~~ COMMISSIONERS AND EXECUTIVE BOARD, ACCOUNTS.

It shall be the duty of the commissioner of human services~~,~~; the commissioner of children, youth, and families; the Direct Care and Treatment executive board~~,~~; and the local social services agencies of the several counties of this state to cause to be deposited with the commissioner of management and budget all moneys and funds in their possession or under their control and designated by section 256.91 as and for the social welfare fund; and all such moneys and funds shall be so deposited in the state treasury as soon as received. The commissioner of human services, in consultation with the commissioner of children, youth, and families and the Direct Care and Treatment executive board, shall keep books of account or other records showing separately the principal amount received and deposited in the social welfare fund for the benefit of any person, together with the name of such person, and the name and address, if known to the commissioner of human services; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board, of the person from whom such money was received; and, at least once every two years, the amount of interest, if any, which the money has earned in the social welfare fund shall be apportioned thereto and posted in the books of account or records to the credit of such beneficiary.

The provisions of sections 256.88 to 256.92 shall not apply to any fund or money now or hereafter deposited or otherwise disposed of pursuant to the lawful orders, decrees, judgments, or other directions of any district court having jurisdiction thereof.

Sec. 50. Minnesota Statutes 2024, section 256G.01, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** This chapter governs the Minnesota human services system. The system includes the Department of Human Services~~,~~; the Department of Children, Youth, and Families; Direct Care and Treatment~~,~~; local social services agencies~~,~~; county welfare agencies~~,~~; human service boards~~,~~; community mental health center boards~~,~~; state hospitals~~,~~; state nursing homes~~,~~; and persons, agencies, institutions, organizations, and other entities under contract to any of those agencies to the extent specified in the contract.

Sec. 51. Minnesota Statutes 2024, section 256G.01, subdivision 3, is amended to read:

Subd. 3. **Program coverage.** This chapter applies to all social service programs administered by the commissioner of human services; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board in which residence is the

determining factor in establishing financial responsibility. These include, but are not limited to: commitment proceedings, including voluntary admissions; emergency holds; poor relief funded wholly through local agencies; social services, including title XX, IV-E and section 256K.10; social services programs funded wholly through the resources of county agencies; social services provided under the Minnesota Indian Family Preservation Act, sections 260.751 to 260.781; costs for delinquency confinement under section 393.07, subdivision 2; service responsibility for these programs; and housing support under chapter 256I.

Sec. 52. Minnesota Statutes 2024, section 256G.03, subdivision 2, is amended to read:

Subd. 2. **No durational test.** Except as otherwise provided in sections 142G.12; 142G.78; 256B.056, subdivision 1; and 256D.02, subdivision 12a for purposes of this chapter, no waiting period is required before securing county or state residence. A person cannot, however, gain residence while physically present in an excluded time facility unless otherwise specified in this chapter or in a federal regulation controlling a federally funded human service; children, youth, and families; or direct care and treatment program. Interstate migrants who enter a shelter for battered women directly from another state can gain residency while in the facility provided the person can provide documentation that the person is a victim of domestic abuse and the county determines that the placement is appropriate.

Sec. 53. Minnesota Statutes 2024, section 256G.04, subdivision 2, is amended to read:

Subd. 2. **Moving out of state.** (a) A person retains county and state residence so long as the person's absence from Minnesota is viewed as a temporary absence within the context of the affected program.

(b) Direct entry into a facility in another state does not end Minnesota residence for purposes of this chapter. Financial responsibility does not continue, however, unless placement was initiated by a human service; children, youth, and families; or direct care and treatment agency or another governmental entity that has statutory authority to bind the human service; children, youth, and families; or direct care and treatment agency and is based on a formal, written plan of treatment, or unless federal regulations require payment for an out-of-state resident.

Sec. 54. Minnesota Statutes 2024, section 256G.09, subdivision 2, is amended to read:

Subd. 2. **Financial disputes.** (a) If the county receiving the transmittal does not believe it is financially responsible, it should provide to the commissioner of human services and the initially responsible county a statement of all facts and documents necessary for the

commissioner to make the requested determination of financial responsibility. The submission must clearly state the program area in dispute and must state the specific basis upon which the submitting county is denying financial responsibility.

(b) The initially responsible county then has 15 calendar days to submit its position and any supporting evidence to the commissioner of human services. The absence of a submission by the initially responsible county does not limit the right of the commissioner of human services; the commissioner of children, youth, and families; or Direct Care and Treatment executive board to issue a binding opinion based on the evidence actually submitted.

(c) A case must not be submitted until the local agency taking the application or making the commitment has made an initial determination about eligibility and financial responsibility, and services have been initiated. This paragraph does not prohibit the submission of closed cases that otherwise meet the applicable statute of limitations.

Sec. 55. Minnesota Statutes 2024, section 256G.09, subdivision 3, is amended to read:

Subd. 3. **Commissioner of human services obligations.** (a) Except as provided in paragraph (b) for matters solely under the jurisdiction of the Direct Care and Treatment executive board or the commissioner of children, youth, and families, the commissioner of human services shall then promptly decide any question of financial responsibility as outlined in this chapter and make an order referring the application to the local agency of the proper county for further action. Further action may include reimbursement by that county of assistance that another county has provided to the applicant under this subdivision. The commissioner shall decide disputes within 60 days of the last county evidentiary submission and shall issue an immediate opinion.

(b) For disputes regarding financial responsibility relating to matters solely under the jurisdiction of the Direct Care and Treatment executive board or the commissioner of children, youth, and families, the commissioner of human services shall promptly issue an advisory opinion on any question of financial responsibility as outlined in this chapter and recommend to the executive board or commissioner of children, youth, and families an order referring the application to the local agency of the proper county for further action. Further action may include reimbursement by that county of assistance that another county has provided to the applicant under this subdivision. The commissioner of human services shall provide an advisory opinion and recommended order to the executive board or commissioner of children, youth, and families within 30 days of the last county evidentiary submission. The executive board or commissioner of children, youth, and families shall decide to accept or reject the commissioner's advisory opinion and recommended order

within 60 days of the last county evidentiary submission and shall issue an immediate opinion stating the reasons for accepting or rejecting the ~~commissioner's~~ recommendation of the commissioner of human services.

(c) The commissioner of human services may make any investigation it considers proper before making a decision or a recommendation to the executive board or commissioner of children, youth, and families. The commissioner of human services may prescribe rules it considers necessary to carry out this subdivision except that the commissioner of human services must not create rules purporting to bind the ~~executive board's~~ decision of the executive board or commissioner of children, youth, and families on any advisory opinion or recommended order under paragraph (b).

(d) Except as provided in paragraph (e) for matters solely under the jurisdiction of the executive board or the commissioner of children, youth, and families, the order of the commissioner of human services binds the local agency involved and the applicant or recipient. That agency shall comply with the order unless reversed on appeal as provided in section 256.045, subdivision 7. The agency shall comply with the order pending the appeal.

(e) For disputes regarding financial responsibility relating to matters solely under the jurisdiction of the Direct Care and Treatment executive board or the commissioner of children, youth, and families, the order of the executive board or the commissioner of children, youth, and families binds the local agency involved and the applicant or recipient. That agency shall comply with the order of the executive board or the commissioner of children, youth, and families unless the order is reversed on appeal as provided in section 142A.20, subdivision 5, or 256.045, subdivision 7. The agency shall comply with the order of the executive board or the commissioner of children, youth, and families pending the appeal.

Sec. 56. Minnesota Statutes 2024, section 256G.09, subdivision 4, is amended to read:

Subd. 4. **Appeals.** A local agency that is aggrieved by the order of the ~~department~~ commissioner of human services, executive board, or commissioner of children, youth, and families under subdivision 3, paragraph (e), may appeal the opinion to the district court of the county responsible for furnishing assistance or services by serving a written copy of a notice of appeal on the commissioner of human services and any adverse party of record within 30 days after the date the department issued the opinion, and by filing the original notice and proof of service with the court administrator of district court. Service may be made personally or by mail. Service by mail is complete upon mailing.

The commissioner of human services; the commissioner of children, youth, and families; or the executive board may elect to become a party to the proceedings in district court. The court may consider the matter in or out of chambers and shall take no new or additional evidence.

Sec. 57. Minnesota Statutes 2024, section 256G.09, subdivision 5, is amended to read:

Subd. 5. **Payment pending appeal.** After the ~~department~~ commissioner of human services, or the executive board or commissioner of children, youth, and families under subdivision 3, paragraph (e), issues an opinion in any submission under this section, the service or assistance covered by the submission must be provided or paid pending or during an appeal to the district court.

Sec. 58. Minnesota Statutes 2024, section 256G.10, is amended to read:

256G.10 DERIVATIVE SETTLEMENT.

(a) The residence of the parent of a minor child, with whom that child last lived in a nonexcluded time setting, or guardian of a ward shall determine the residence of the child or ward for all social services governed by this chapter.

(b) For purposes of this chapter, a minor child is defined as being under 18 years of age unless otherwise specified in a program administered by the commissioner of human services; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board.

(c) Physical or legal custody has no bearing on residence determinations. This section does not, however, apply to situations involving another state, limit the application of an interstate compact, or apply to situations involving state wards where the commissioner of human services or children, youth, and families is defined by law as the guardian.

Sec. 59. Minnesota Statutes 2024, section 256G.11, is amended to read:

256G.11 NO RETROACTIVE EFFECT.

(a) This chapter is not retroactive and does not require redetermination of financial responsibility for cases existing on January 1, 1988. This chapter applies only to applications and redeterminations of eligibility taken or routinely made after January 1, 1988.

(b) Notwithstanding this section, existing social services cases shall be treated in the same manner as cases for those programs outlined in section 256G.02, subdivision 4,

paragraph (g), for which an application is taken or a redetermination is made after January 1, 1988.

(c) The requirement under section 256G.09, subdivision 3, for the Direct Care and Treatment executive board or the commissioner of children, youth, and families to accept or reject the recommendation of the commissioner of humans services regarding the county of financial responsibility for matters solely under the jurisdiction of the executive board or the commissioner of children, youth, and families is not retroactive and does not require redetermination of financial responsibility for cases existing prior to the effective date of the transfer of all authorities and responsibilities from the Department of Human Services to Direct Care and Treatment.

(d) Notwithstanding paragraph (c), existing cases relating to matters under the jurisdiction of the executive board must be treated in the same manner as cases relating to matters under the jurisdiction of the executive board opened or redetermined after the effective date of the transfer of all authorities and responsibilities from the Department of Human Services to Direct Care and Treatment or the Department of Children, Youth, and Families.

Sec. 60. Minnesota Statutes 2024, section 256G.12, subdivision 1, is amended to read:

Subdivision 1. **Limitation.** A submission to the commissioner of human services; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board for a determination of financial responsibility must be made within three years from the date of application for the program in question or from the date of admission or commitment to state or other institutions.

Sec. 61. Minnesota Statutes 2024, section 260.762, subdivision 2a, is amended to read:

Subd. 2a. **Required findings that active efforts were provided.** (a) A court shall not order a child placement, termination of parental rights, guardianship to the commissioner of children, youth, and families under section 260C.325, or temporary or permanent change in custody of an Indian child unless the court finds that the child-placing agency or petitioner demonstrated that active efforts were made to preserve the Indian child's family. Active efforts to preserve the Indian child's family include efforts to prevent placement of the Indian child to correct the conditions that led to the placement by ensuring remedial services and rehabilitative programs designed to prevent the breakup of the family were provided in a manner consistent with the prevailing social and cultural conditions of the Indian child's Tribe and in partnership with the Indian child, the Indian child's parents, the Indian custodian, extended family members, and Tribe, and that these efforts have proved unsuccessful.

(b) The court, in determining whether active efforts were made to preserve the Indian child's family for purposes of child placement or permanency, shall ensure the provision of active efforts designed to correct the conditions that led to the placement of the Indian child and shall make findings regarding whether the following activities were appropriate and necessary, and whether the child-placing agency or petitioner ensured appropriate and meaningful services were available based upon the family's specific needs, whether listed in this paragraph or not:

(1) whether active efforts were made at the earliest point possible to inquire into the child's heritage, to identify any federally recognized Indian Tribe the child may be affiliated with, to notify all potential Tribes at the earliest point possible, and to request participation of the Indian child's Tribe;

(2) whether a Tribally designated representative with substantial knowledge of the prevailing social and cultural standards and child-rearing practices within the Tribal community was provided an opportunity to consult with and be involved in any investigations or assessments of the family's circumstances, participate in identifying the family's needs, and participate in development of any plan to keep the Indian child safely in the home, identify services designed to prevent the breakup of the Indian child's family, and to reunify the Indian child's family as soon as safety can be assured if out-of-home placement has occurred;

(3) whether the Tribal representative was provided with all information available regarding the proceeding, and whether it was requested that the Tribal representative assist in identifying services designed to prevent the breakup of the Indian child's family and to reunify the Indian child's family as soon as safety can be assured if out-of-home placement has occurred;

(4) whether, before making a decision that may affect an Indian child's safety and well-being or when contemplating placement of an Indian child, guidance from the Indian child's Tribe was sought regarding family structure, how the family can seek help, what family and Tribal resources are available, and what barriers the family faces that could threaten the family's preservation;

(5) whether a Tribal representative was consulted to determine and arrange for visitation in the most natural setting that ensures the Indian child's safety, when the Indian child's safety requires supervised visitation;

(6) whether early and ongoing efforts occurred to identify, locate, and include extended family members as supports for the Indian child and the Indian child's family;

(7) whether continued active efforts were made to identify and place the Indian child in a home that is compliant with the placement preferences in sections 260.751 to 260.835, including whether extended family members were consulted to provide support to the Indian child and Indian child's parents; to inform the child-placing agency, petitioner, and court as to cultural connections and family structure; to assist in identifying appropriate cultural services and supports for the Indian child and Indian child's parents; and to identify and serve as placement and permanency resources for the Indian child. If there was difficulty contacting or engaging extended family members, whether assistance was sought from the Tribe~~,~~; the Department of Human Services~~,~~; the Department of Children, Youth, and Families; or other agencies with expertise in working with Indian families;

(8) whether services and resources were provided to extended family members who are considered the primary placement option for an Indian child, as agreed upon by the child-placing agency or petitioner and the Tribe, to overcome licensing and other barriers to providing care to an Indian child. The need for services or resources shall not be a basis to exclude an extended family member from consideration as a primary placement. Services and resources include but are not limited to child care assistance, financial assistance, housing resources, emergency resources, and foster care licensing assistance and resources;

(9) whether concrete services and access to both Tribal and non-Tribal services were provided to the Indian child's parents and Indian custodian and, where necessary, members of the Indian child's extended family members who provide support to the Indian child and the Indian child's parents; and whether these services were provided in an ongoing manner throughout the child-placing agency or petitioner's involvement with the Indian family to directly assist the Indian family in accessing and utilizing services to maintain the Indian family, or to reunify the Indian family as soon as safety can be assured if out-of-home placement has occurred. Services include but are not limited to financial assistance, food, housing, health care, transportation, in-home services, community support services, and specialized services; and

(10) whether visitation occurred whenever possible in the home of the Indian child's parent, Indian custodian, or extended family member or in another noninstitutional setting in order to keep the Indian child in close contact with the Indian child's parents, siblings, and other relatives regardless of the Indian child's age and to allow the Indian child and those with whom the Indian child visits to have natural, unsupervised interaction when consistent with protecting the child's safety.

Sec. 62. Minnesota Statutes 2024, section 260B.171, subdivision 4, is amended to read:

Subd. 4. **Public inspection of records.** (a) Legal records arising from proceedings or portions of proceedings that are public under section 260B.163, subdivision 1, are open to public inspection.

(b) Except as otherwise provided by this section, none of the records of the juvenile court and none of the records relating to an appeal from a nonpublic juvenile court proceeding, except the written appellate opinion, shall be open to public inspection or their contents disclosed except:

(1) by order of a court; or

(2) as required by chapter 245C or sections 142B.10, 245A.04, 611A.03, 611A.04, 611A.06, and 629.73.

(c) The victim of any alleged delinquent act may, upon the victim's request, obtain the following information, unless it reasonably appears that the request is prompted by a desire on the part of the requester to engage in unlawful activities:

(1) the name and age of the juvenile;

(2) the act for which the juvenile was petitioned and date of the offense; and

(3) the disposition, including, but not limited to, dismissal of the petition, diversion, probation and conditions of probation, detention, fines, or restitution.

(d) The records of juvenile probation officers and county home schools are records of the court for the purposes of this subdivision. Court services data relating to delinquent acts that are contained in records of the juvenile court may be released as allowed under section 13.84, subdivision 6. This subdivision applies to all proceedings under this chapter, including appeals from orders of the juvenile court, except that this subdivision does not apply to proceedings under section 260B.335 or 260B.425 when the proceeding involves an adult defendant. The court shall maintain the confidentiality of adoption files and records in accordance with the provisions of laws relating to adoptions. In juvenile court proceedings any report or social history furnished to the court shall be open to inspection by the attorneys of record and the guardian ad litem a reasonable time before it is used in connection with any proceeding before the court.

(e) When a judge of a juvenile court, or duly authorized agent of the court, determines under a proceeding under this chapter that a child has violated a state or local law, ordinance, or regulation pertaining to the operation of a motor vehicle on streets and highways, except parking violations, the judge or agent shall immediately report the violation to the

commissioner of public safety. The report must be made on a form provided by the Department of Public Safety and must contain the information required under section 169.95.

(f) A county attorney may give a law enforcement agency that referred a delinquency matter to the county attorney a summary of the results of that referral, including the details of any juvenile court disposition.

Sec. 63. Minnesota Statutes 2024, section 260E.03, subdivision 6, is amended to read:

Subd. 6. **Facility.** "Facility" means:

(1) a licensed or unlicensed day care facility, certified license-exempt child care center, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 142B, 142C, 144H, or 245D;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

Sec. 64. Minnesota Statutes 2024, section 260E.11, subdivision 1, is amended to read:

Subdivision 1. **Reports of maltreatment in facility.** A person mandated to report child maltreatment occurring within a licensed facility shall report the information to the agency responsible for licensing or certifying the facility under sections 144.50 to 144.58, 241.021, and 245A.01 to 245A.16~~;~~ or chapter 142B, 142C, 144H, or 245D~~;~~ or to a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

Sec. 65. Minnesota Statutes 2024, section 260E.30, subdivision 4, is amended to read:

Subd. 4. **Mitigating factors in investigating facilities.** (a) When determining whether the facility or individual is the responsible party or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or

directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

(b) The evaluation of the facility's responsibility under paragraph (a), clause (2), must not be based on the completeness of the risk assessment or risk reduction plan required under section ~~245A.66~~ 142B.54, but must be based on the facility's compliance with the regulatory standards for policies and procedures, training, and supervision as cited in Minnesota Statutes and Minnesota Rules.

(c) Notwithstanding paragraphs (a) and (b), when maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing or certification actions under section 142B.16, 142B.18, 142C.06, 142C.07, 245A.06, or 245A.07 apply.

Sec. 66. Minnesota Statutes 2024, section 260E.33, subdivision 6, is amended to read:

Subd. 6. **Contested case hearing.** If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 142B.15 or 245A.05 or a licensing sanction under section 142B.18 or 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 142B.20, subdivision 3, or 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination and disqualification shall not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination as provided under this subdivision and reconsideration of a disqualification as provided under section 245C.22 shall also not be conducted when:

(1) a denial of a license under section 142B.15 or 245A.05 or a licensing sanction under section 142B.18 or 245A.07 is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under subdivision 2 and section 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under subdivision 2 and sections 245C.27 and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

Sec. 67. Minnesota Statutes 2024, section 261.232, is amended to read:

261.232 DUTIES OF ~~COMMISSIONER~~ COMMISSIONERS OF HUMAN SERVICES AND CHILDREN, YOUTH, AND FAMILIES.

The ~~commissioner~~ commissioners of human services and children, youth, and families shall promulgate rules to establish administrative and fiscal procedures for payment of the state share of the costs incurred by the counties under sections 261.21 to 261.231. The rules may include:

(a) procedures by which state liability for the costs of hospitalization of indigent persons may be deducted from county liability to the state under any other public assistance program authorized by law;

(b) procedures for processing claims of counties for reimbursement by the state for expenditures made by the counties for the hospitalization of indigent persons; and

(c) standards for eligibility and utilization of medical care.

Sec. 68. Minnesota Statutes 2024, section 270B.14, subdivision 1, is amended to read:

Subdivision 1. **Disclosure to commissioner of human services.** ~~(a) On the request of the commissioner of human services, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).~~

~~(b) Data that may be disclosed are limited to data relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.~~

~~(c) The commissioner of human services may request data only for the purposes of carrying out the child support enforcement program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 518A.83.~~

~~(d)~~ (a) The commissioner shall provide the records and information necessary to administer the supplemental housing allowance to the commissioner of human services.

~~(e)~~ (b) At the request of the commissioner of human services, the commissioner of revenue shall electronically match the Social Security or individual taxpayer identification numbers and names of participants in the telephone assistance plan operated under sections 237.69 to 237.71, with those of property tax refund filers under chapter 290A or renter's credit filers under section 290.0693, and determine whether each participant's household income is within the eligibility standards for the telephone assistance plan.

~~(f)~~ (c) The commissioner may provide records and information collected under sections 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234. Upon the written agreement by the United States Department of Health and Human Services to maintain the confidentiality of the data, the commissioner may provide records and information collected under sections 295.50 to 295.59 to the Centers for Medicare and Medicaid Services section of the United States Department of Health and Human Services for purposes of meeting federal reporting requirements.

~~(g)~~ (d) The commissioner may provide records and information to the commissioner of human services as necessary to administer the early refund of refundable tax credits.

~~(h)~~ (e) The commissioner may disclose information to the commissioner of human services as necessary for income verification for eligibility and premium payment under

the MinnesotaCare program, under section 256L.05, subdivision 2, as well as the medical assistance program under chapter 256B.

~~(i)~~ (f) The commissioner may disclose information to the commissioner of human services necessary to verify whether applicants or recipients for ~~the Minnesota family investment program,~~ general assistance~~, the Supplemental Nutrition Assistance Program (SNAP),~~ and the Minnesota supplemental aid program~~, and child care assistance~~ have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

~~(j)~~ (g) At the request of the commissioner of human services and when authorized in writing by the taxpayer, the commissioner of revenue may match the business legal name or individual legal name, and the Minnesota tax identification number, federal Employer Identification Number, or Social Security number of the applicant under section 142C.03; 245A.04, subdivision 1; or 245I.20; or license or certification holder. The commissioner of revenue may share the matching with the commissioner of human services. The matching may only be used by the commissioner of human services to determine eligibility for provider grant programs and to facilitate the regulatory oversight of license and certification holders as it relates to ownership and public funds program integrity. This paragraph applies only if the commissioner of human services and the commissioner of revenue enter into an interagency agreement for the purposes of this paragraph.

Sec. 69. Minnesota Statutes 2024, section 270B.14, is amended by adding a subdivision to read:

Subd. 24. **Disclosure to commissioner of children, youth, and families.** (a) On the request of the commissioner of children, youth, and families, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

(b) Data may be disclosed relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.

(c) The commissioner of children, youth, and families may request data for the purposes of carrying out the child support program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 518A.83.

(d) The commissioner may disclose information to the commissioner of children, youth, and families necessary to verify whether applicants or recipients for the Minnesota family investment program, the Supplemental Nutrition Assistance Program, and child care assistance have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

Sec. 70. Minnesota Statutes 2024, section 299C.76, subdivision 1, is amended to read:

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

(b) "Federal tax information" means federal tax returns and return information or information derived or created from federal tax returns, in possession of or control by the requesting agency, that is covered by the safeguarding provisions of section 6103(p)(4) of the Internal Revenue Code.

(c) "IRS Publication 1075" means Internal Revenue Service Publication 1075 that provides guidance and requirements for the protection and confidentiality of federal tax information as required in section 6103(p)(4) of the Internal Revenue Code.

(d) "National criminal history record information" means the Federal Bureau of Investigation identification records as defined in Code of Federal Regulations, title 28, section 20.3(d).

(e) "Requesting agency" means the Department of Revenue~~,~~; Department of Employment and Economic Development~~,~~; Department of Human Services; Department of Children, Youth, and Families~~,~~; board of directors of MNsure~~,~~; Department of Information Technology Services~~,~~; attorney general~~,~~; and counties.

Sec. 71. Minnesota Statutes 2024, section 299F.011, subdivision 4a, is amended to read:

Subd. 4a. **Day care home regulation.** (a) Notwithstanding any contrary provision of this section, the fire marshal shall not adopt or enforce a rule:

(1) establishing staff ratios, age distribution requirements, and limitations on the number of children in care;

(2) regulating the means of egress from family or group family day care homes in addition to the egress rules that apply to the home as a single family dwelling; or

(3) confining family or group family day care home activities to the floor of exit discharge.

(b) For purposes of this subdivision, "family or group family day care home" means a dwelling unit in which the day care provider provides the services referred to in section 142B.01, subdivision 18, to one or more persons.

(c) Nothing in this subdivision prohibits the Department of Children, Youth, and Families from adopting or enforcing rules regulating day care, including the subjects in paragraph (a), clauses (1) and (3). The department may not, however, adopt or enforce a rule stricter than paragraph (a), clause (2).

(d) The Department of ~~Human Services~~ Children, Youth, and Families may by rule adopt procedures for requesting the state fire marshal or a local fire marshal to conduct an inspection of day care homes to ensure compliance with state or local fire codes.

(e) The commissioners of public safety; children, youth, and families; and human services may enter into an agreement for the ~~commissioner~~ commissioners of human services and children, youth, and families to perform follow-up inspections of programs, subject to licensure under chapter 142B or 245A, to determine whether certain violations cited by the state fire marshal have been corrected. The agreement shall identify specific items the commissioner of human services is permitted to inspect. The list of items is not subject to rulemaking and may be changed by mutual agreement between the state fire marshal and the commissioner. The agreement shall provide for training of individuals who will conduct follow-up inspections. The agreement shall contain procedures for the commissioner of human services to follow when the commissioner requires assistance from the state fire marshal to carry out the duties of the agreement.

(f) No tort liability is transferred to the commissioner of human services or the commissioner of children, youth, and families as a result of the ~~commissioner of human services~~ commissioners performing activities within the limits of the agreement.

Sec. 72. Minnesota Statutes 2024, section 402A.10, subdivision 1a, is amended to read:

Subd. 1a. **Balanced set of program measures.** A "balanced set of program measures" is a set of measures that, together, adequately quantify achievement toward a particular program's outcome. As directed by section 402A.16, the Human Services Performance Council must recommend to the commissioner ~~when~~ who oversees a particular program when the program has a balanced set of program measures.

Sec. 73. Minnesota Statutes 2024, section 402A.10, subdivision 2, is amended to read:

Subd. 2. ~~**Commissioner**~~ **Commissioners.** ~~"Commissioner"~~ "Commissioners" means the ~~commissioner~~ commissioners of human services and children, youth, and families.

Sec. 74. Minnesota Statutes 2024, section 402A.10, subdivision 4c, is amended to read:

Subd. 4c. **Performance improvement plan.** A "performance improvement plan" means a plan developed by a county or service delivery authority that describes steps the county or service delivery authority must take to improve performance on a specific measure or set of measures. The performance improvement plan must be negotiated with and approved by ~~the~~ each commissioner who oversees a program affected by the plan. The performance improvement plan must require a specific numerical improvement in the measure or measures on which the plan is based and may include specific programmatic best practices or specific performance management practices that the county must implement.

Sec. 75. Minnesota Statutes 2024, section 402A.12, is amended to read:

402A.12 ESTABLISHMENT OF A PERFORMANCE MANAGEMENT SYSTEM FOR HUMAN SERVICES.

By January 1, 2014, the commissioner of human services shall implement a performance management system for essential human services as described in sections 402A.16 and 402A.18 that includes initial performance measures and thresholds consistent with the recommendations of the Steering Committee on Performance and Outcome Reforms in the December 2012 report to the legislature.

Sec. 76. Minnesota Statutes 2024, section 402A.16, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** By October 1, 2013, the commissioner of human services shall convene a Human Services Performance Council to advise the commissioner of human services on the implementation and operation of the performance management system for human services.

Sec. 77. Minnesota Statutes 2024, section 402A.16, subdivision 2, is amended to read:

Subd. 2. **Duties.** The Human Services Performance Council shall:

(1) hold meetings at least quarterly that are in compliance with Minnesota's Open Meeting Law under chapter 13D;

(2) annually review the annual performance data submitted by counties or service delivery authorities;

(3) review and advise the ~~commissioner~~ commissioners on department procedures related to the implementation of the performance management system and system process requirements and on barriers to process improvement in human services delivery;

(4) advise the ~~commissioner~~ commissioners on the training and technical assistance needs of county or service delivery authority and department personnel;

(5) review instances in which a county or service delivery authority has not made adequate progress on a performance improvement plan and make recommendations to the ~~commissioner~~ commissioners under section 402A.18;

(6) consider appeals from counties or service delivery authorities that are in the remedies process and make recommendations to the ~~commissioner~~ commissioners on resolving the issue;

(7) convene working groups to update and develop outcomes, measures, and performance thresholds for the performance management system and, on an annual basis, present these recommendations to the ~~commissioner~~ commissioners, including recommendations on when a particular essential human services program has a balanced set of program measures in place;

(8) make recommendations on human services administrative rules or statutes that could be repealed in order to improve service delivery; and

(9) provide information to stakeholders on the council's role and regularly collect stakeholder input on performance management system performance.

Sec. 78. Minnesota Statutes 2024, section 402A.16, subdivision 3, is amended to read:

Subd. 3. **Membership.** (a) Human Services Performance Council membership shall be equally balanced among the following five stakeholder groups: the Association of Minnesota Counties~~,~~; the Minnesota Association of County Social Service Administrators~~,~~; the Department of Human Services~~,~~ and the Department of Children, Youth, and Families, jointly; tribes and communities of color~~,~~; and service providers and advocates for persons receiving human services. The Association of Minnesota Counties and the Minnesota Association of County Social Service Administrators shall appoint their own respective representatives. The ~~commissioner of human services~~ commissioners shall each appoint two representatives of ~~the Department of Human Services,~~ their respective department. The commissioners shall each appoint two representatives from (1) tribes and communities of

color~~,~~ and (2) social services providers and advocates. ~~Minimum~~ Council membership shall be ~~15~~ 20 members, with ~~at least three~~ four representatives from each nondepartmental stakeholder group~~, and maximum council membership shall be 20 members, with four representatives from each stakeholder group~~.

(b) Notwithstanding section 15.059, Human Services Performance Council members shall be appointed for a minimum of two years~~,~~ but may serve longer terms at the discretion of their appointing authority.

(c) Notwithstanding section 15.059, members of the council shall receive no compensation for their services.

(d) A ~~commissioner's~~ representative from each commissioner and a county representative from either the Association of Minnesota Counties or the Minnesota Association of County Social Service Administrators shall serve as Human Services Performance Council cochairs.

Sec. 79. Minnesota Statutes 2024, section 402A.16, subdivision 4, is amended to read:

Subd. 4. ~~**Commissioner**~~ **Commissioners' duties.** For essential human services administered by each agency, the ~~commissioner~~ commissioners shall:

(1) implement and maintain the performance management system for human services;

(2) establish and regularly update the system's outcomes, measures, and thresholds, including the minimum performance threshold for each performance measure;

(3) determine when a particular program has a balanced set of measures;

(4) receive reports from counties or service delivery authorities at least annually on their performance against system measures, provide counties with data needed to assess performance and monitor progress, and provide timely feedback to counties or service delivery authorities on their performance;

(5) implement and monitor the remedies process in section 402A.18;

(6) report to the Human Services Performance Council on county or service delivery authority performance on a semiannual basis;

(7) provide general training and technical assistance to counties or service delivery authorities on topics related to performance measurement and performance improvement;

(8) provide targeted training and technical assistance to counties or service delivery authorities that supports their performance improvement plans; and

(9) provide staff support for the Human Services Performance Council.

Sec. 80. Minnesota Statutes 2024, section 402A.18, subdivision 2, is amended to read:

Subd. 2. **Underperforming county; more than one-half of services.** If the ~~commissioner determines~~ commissioners determine that a county or service delivery authority is deficient in achieving minimum performance thresholds for more than one-half of the defined essential human services programs, the ~~commissioner~~ commissioners may impose the following remedies:

(1) voluntary incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies;

(2) mandatory incorporation of the administration and operation of essential human services programs with an existing service delivery authority or another county. A service delivery authority or county incorporating an underperforming county shall not be financially liable for the costs associated with remedying performance outcome deficiencies; or

(3) transfer of authority for administration and operation of essential human services programs to the commissioner that oversees each program.

Sec. 81. Minnesota Statutes 2024, section 402A.18, subdivision 3, is amended to read:

Subd. 3. **Conditions prior to imposing remedies.** (a) The commissioner shall notify a county or service delivery authority that it must submit a performance improvement plan if:

(1) the county or service delivery authority does not meet the minimum performance threshold for a measure; or

(2) the county or service delivery authority has a performance disparity for a racial or ethnic subgroup, even if the county or service delivery authority met the threshold for the overall population. The council shall make recommendations on performance disparities, and the commissioner shall make the final determination.

(b) When the ~~department~~ commissioner determines that a county or service delivery authority does not meet the minimum performance threshold for a given measure, the commissioner must advise the county or service delivery authority that fiscal penalties may result if the performance does not improve. The ~~department~~ commissioner must offer technical assistance to the county or service delivery authority. Within 30 days of the initial advisement from the ~~department~~ commissioner, the county or service delivery authority may claim and the ~~department~~ commissioner may approve an extenuating circumstance

that relieves the county or service delivery authority of any further remedy. If a county or service delivery authority has a small number of participants in an essential human services program such that reliable measurement is not possible, the commissioner may approve extenuating circumstances.

(c) If there are no extenuating circumstances, the county or service delivery authority must submit a performance improvement plan to the commissioner within 60 days of the initial advisement from the ~~department~~ commissioner. The term of the performance improvement plan must be two years, starting with the date the plan is approved by the commissioner. This plan must include a target level for improvement for each measure that did not meet the minimum performance threshold. The commissioner must approve the performance improvement plan within 60 days of submittal.

(d) The ~~department~~ commissioner must monitor the performance improvement plan for two years. After two years, if the county or service delivery authority meets the minimum performance threshold, there is no further remedy. If the county or service delivery authority fails to meet the minimum performance threshold~~,~~ but meets the improvement target in the performance improvement plan, the county or service delivery authority shall modify the performance improvement plan for further improvement and the ~~department~~ commissioner shall continue to monitor the plan.

(e) If, after two years of monitoring, the county or service delivery authority fails to meet both the minimum performance threshold and the improvement target identified in the performance improvement plan, the next step of the remedies process shall be invoked by the commissioner. This phase of the remedies process may include:

(1) fiscal penalties for the county or service delivery authority that do not exceed one percent of the county's human services expenditures and that are negotiated in the performance improvement plan, based on what is needed to improve outcomes. Counties or service delivery authorities must reinvest the amount of the fiscal penalty into the essential human services program that was underperforming. A county or service delivery authority shall not be required to pay more than three fiscal penalties in a year; and

(2) the ~~department's~~ commissioner's provision of technical assistance to the county or service delivery authority that is targeted to address the specific performance issues.

The commissioner shall continue monitoring the performance improvement plan for a third year.

(f) If, after the third year of monitoring, the county or service delivery authority meets the minimum performance threshold, there is no further remedy. If the county or service

delivery authority fails to meet the minimum performance threshold~~,~~ but meets the improvement target for the performance improvement plan, the county or service delivery authority shall modify the performance improvement plan for further improvement and the ~~department~~ commissioner shall continue to monitor the plan.

(g) If, after the third year of monitoring, the county or service delivery authority fails to meet the minimum performance threshold and the improvement target identified in the performance improvement plan, the Human Services Performance Council shall review the situation and recommend a course of action to the commissioner.

(h) If the commissioner has determined that a program has a balanced set of program measures and a county or service delivery authority is subject to fiscal penalties for more than one-half of the measures for that program, the commissioner may apply further remedies as described in subdivisions 1 and 2.

Sec. 82. Minnesota Statutes 2024, section 402A.18, is amended by adding a subdivision to read:

Subd. 4. **Commissioner jurisdiction.** For purposes of this section, "commissioner" means the commissioner of human services or the commissioner of children, youth, and families, whichever oversees the program or service at issue. If programs or services overseen by both commissioners are at issue, commissioner means both commissioners jointly. A commissioner must not take action under this section for a program or service that the commissioner does not oversee.

Sec. 83. Minnesota Statutes 2024, section 402A.35, subdivision 1, is amended to read:

Subdivision 1. **Requirements for establishing a service delivery authority.** (a) A county, tribe, or consortium of counties is eligible to establish a service delivery authority if:

(1) the county, tribe, or consortium of counties is:

(i) a single county with a population of 55,000 or more;

(ii) a consortium of counties with a total combined population of 55,000 or more;

(iii) a consortium of four or more counties in reasonable geographic proximity without regard to population; or

(iv) one or more tribes with a total combined population of 25,000 or more.

The council may recommend that the ~~commissioner of human services~~ commissioners exempt a single county, tribe, or consortium of counties from the minimum population standard if the county, tribe, or consortium of counties can demonstrate that it can otherwise meet the requirements of this chapter.

(b) A service delivery authority shall:

(1) comply with current state and federal law, including any existing federal or state performance measures when they are enacted into law, except where waivers are approved by the ~~commissioner~~ commissioners;

(2) define the scope of essential services over which the service delivery authority has jurisdiction;

(3) designate a single administrative structure to oversee the delivery of those services included in a proposal for a redesigned service or services and identify a single administrative agent for purposes of contact and communication with the department;

(4) identify the waivers from statutory or rule program requirements that are needed to ensure greater local control and flexibility to determine the most cost-effective means of achieving specified measurable goals that the participating service delivery authority is expected to achieve;

(5) set forth a reasonable level of targeted reductions in overhead and administrative costs for each service delivery authority participating in the service delivery redesign;

(6) set forth the terms under which a county, tribe, or consortium of counties may withdraw from participation. In the case of withdrawal of any or all parties or the dissolution of the service delivery authority, the employees shall continue to be represented by the same exclusive representative or representatives and continue to be covered by the same collective bargaining union agreement until a new agreement is negotiated or the collective bargaining agreement term ends; and

(7) set forth a structure for managing the terms and conditions of employment of the employees as provided in section 402A.40.

(c) Once a county, tribe, or consortium of counties establishes a service delivery authority, no county, tribe, or consortium of counties that is a member of the service delivery authority may participate as a member of any other service delivery authority. The service delivery authority may allow an additional county, a tribe, or a consortium of counties to join the service delivery authority subject to the approval of the council and the ~~commissioner~~ commissioners.

(d) Nothing in this chapter precludes local governments from using sections 465.81 and 465.82 to establish procedures for local governments to merge, with the consent of the voters. Nothing in this chapter limits the authority of a county board or tribal council to enter into contractual agreements for services not covered by the provisions of a memorandum of understanding establishing a service delivery authority with other agencies or with other units of government.

Sec. 84. Minnesota Statutes 2024, section 402A.35, subdivision 4, is amended to read:

Subd. 4. **Process for establishing a service delivery authority.** (a) The county, tribe, or consortium of counties meeting the requirements of this section and proposing to establish a service delivery authority shall present to the council:

(1) in conjunction with the ~~commissioner~~ commissioners, a proposed memorandum of understanding meeting the requirements of subdivision 1, paragraph (b), and outlining:

(i) the details of the proposal;

(ii) the state, tribal, and local resources, which may include, but are not limited to, funding, administrative and technology support, and other requirements necessary for the service delivery authority; and

(iii) the relief available to the service delivery authority if the resource commitments identified in item (ii) are not met; and

(2) a board resolution from the board of commissioners of each participating county stating the county's intent to participate, or in the case of a tribe, a resolution from tribal government, stating the tribe's intent to participate.

(b) After the council has considered and recommended approval of a proposed memorandum of understanding, the ~~commissioner~~ commissioners may finalize and execute the memorandum of understanding.

Sec. 85. Minnesota Statutes 2024, section 402A.35, subdivision 5, is amended to read:

Subd. 5. **Commissioner authority to seek waivers.** The ~~commissioner~~ commissioners may use the authority under section 142A.03, subdivision 2, paragraph (k), or 256.01, subdivision 2, paragraph (k), to grant waivers identified as part of a proposed service delivery authority under subdivision 1, paragraph (b), clause (4), except that waivers granted under this section must be approved by the council under section 402A.20 rather than the Legislative Advisory Committee.

Sec. 86. Minnesota Statutes 2024, section 462A.2095, subdivision 6, is amended to read:

Subd. 6. **Rent assistance not income.** (a) Notwithstanding any law to the contrary, payments under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for state public assistance, including but not limited to:

(1) child care assistance programs under chapter 142E;

(2) food support under chapter 142F;

~~(2)~~ (3) general assistance~~,~~ and Minnesota supplemental aid~~, and food support~~ under chapter 256D;

~~(3)~~ (4) housing support under chapter 256I;

~~(4)~~ (5) Minnesota family investment program and diversionary work program under chapter 142G; and

~~(5)~~ (6) economic assistance programs under chapter 256P.

(b) The commissioner of human services must not consider rent assistance grant money under this section as income or assets under section 256B.056, subdivision 1a, paragraph (a); subdivision 3; or subdivision 3c, or for persons with eligibility determined under section 256B.057, subdivision 3, 3a, or 3b.

Sec. 87. Minnesota Statutes 2024, section 466.131, is amended to read:

466.131 INDEMNIFICATION BY STATE.

Until July 1, 1987, a municipality is an employee of the state for purposes of the indemnification provisions of section 3.736, subdivision 9, when the municipality is required by the Public Welfare Licensing Act and rules promulgated under it to inspect or investigate a provider. After July 1, 1987, a municipality is an employee of the state for purposes of the indemnification provisions of section 3.736, subdivision 9, when the municipality is required by sections 245A.01 to 245A.16~~, the Human Services Licensing Act,~~ or chapter 142B and rules adopted under it to inspect or investigate a provider~~,~~ and the municipality has been duly certified under standards for certification developed by the ~~commissioner~~ commissioners of human services and children, youth, and families.

Sec. 88. Minnesota Statutes 2024, section 518.165, subdivision 5, is amended to read:

Subd. 5. **Procedure, criminal history, and maltreatment records background study.** (a) When the court requests a background study under subdivision 4, paragraph (a),

the request shall be submitted to the Department of Human Services through the department's electronic online background study system.

(b) When the court requests a search of the National Criminal Records Repository, the court must provide a set of classifiable fingerprints of the subject of the study on a fingerprint card provided by the commissioner of human services.

(c) The commissioner of human services shall provide the court with criminal history data as defined in section 13.87 from the Bureau of Criminal Apprehension in the Department of Public Safety, other criminal history data held by the commissioner of human services, and data regarding substantiated maltreatment of a minor under chapter 260E, and substantiated maltreatment of a vulnerable adult under section 626.557, within 15 working days of receipt of a request. If the subject of the study has been determined by the Department of Human Services; the Department of Children, Youth, and Families; or the Department of Health to be the perpetrator of substantiated maltreatment of a minor or vulnerable adult in a licensed facility, the response must include a copy of the public portion of the investigation memorandum under section 260E.30 or the public portion of the investigation memorandum under section 626.557, subdivision 12b. When the background study shows that the subject has been determined by a county adult protection or child protection agency to have been responsible for maltreatment, the court shall be informed of the county, the date of the finding, and the nature of the maltreatment that was substantiated. The commissioner shall provide the court with information from the National Criminal Records Repository within three working days of the commissioner's receipt of the data. When the commissioner finds no criminal history or substantiated maltreatment on a background study subject, the commissioner shall make these results available to the court electronically through the secure online background study system.

(d) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner or county lead agency or lead investigative agency has information that a person on whom a background study was previously done under this section has been determined to be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the county may provide this information to the court that requested the background study.

Sec. 89. Minnesota Statutes 2024, section 524.5-106, is amended to read:

524.5-106 SUBJECT-MATTER JURISDICTION.

This article applies to, and the court has jurisdiction over, guardianship and related proceedings for individuals domiciled or present in this state, protective proceedings for individuals domiciled in or having property located in this state, and property coming into

the control of a guardian or conservator who is subject to the laws of this state. This article does not apply to any matters or proceedings arising under or governed by chapters 252A, 259, and 260C. Notwithstanding anything else to the contrary, chapters 252A, 259, and 260C exclusively govern the rights, duties, and powers of social service agencies~~,~~; the commissioner of human services~~,~~; the commissioner of children, youth, and families; licensed child placing agencies~~,~~; and parties with respect to all matters and proceedings arising under those chapters.

Sec. 90. Minnesota Statutes 2024, section 524.5-118, subdivision 2, is amended to read:

Subd. 2. **Procedure; maltreatment and state licensing agency checks and criminal history check.** (a) The guardian or conservator shall request the Bureau of Criminal Apprehension to complete a criminal history check. The request must be accompanied by the applicable fee and acknowledgment that the guardian or conservator received a privacy notice. The Bureau of Criminal Apprehension shall conduct a national criminal history record check. The guardian or conservator shall submit a set of classifiable fingerprints. The fingerprints must be recorded on a fingerprint card provided by the Bureau of Criminal Apprehension.

(b) The Bureau of Criminal Apprehension shall provide the court with criminal history data as defined in section 13.87 and criminal history information from other states or jurisdictions as indicated from a national criminal history record check within 20 working days of receipt of a request.

(c) In accordance with section 245C.033, the commissioner of human services shall provide the court with data regarding substantiated maltreatment of vulnerable adults under section 626.557 and substantiated maltreatment of minors under chapter 260E within 25 working days of receipt of a request. If the guardian or conservator has been the perpetrator of substantiated maltreatment of a vulnerable adult or minor, the response must include a copy of any available public portion of the investigation memorandum under section 626.557, subdivision 12b, or any available public portion of the investigation memorandum under section 260E.30.

(d) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner of human services; the commissioner of children, youth, and families; or a county lead agency or lead investigative agency has information that a person under this section has been determined to be a perpetrator of maltreatment of a vulnerable adult or minor, the commissioner or the county may provide this information to the court that is determining eligibility for the guardian or conservator.

Sec. 91. Minnesota Statutes 2024, section 595.02, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) The exception provided by paragraphs (d) and (g) of subdivision 1 shall not apply to any testimony, records, or other evidence relating to the abuse or neglect of a minor in any proceeding under chapter 260 or any proceeding under section 142B.20 or 245A.08, to revoke a day care or foster care license, arising out of the neglect or physical or sexual abuse of a minor, as defined in section 260E.03.

(b) The exception provided by paragraphs (d) and (g) of subdivision 1 shall not apply to criminal proceedings arising out of the neglect or physical or sexual abuse of a minor, as defined in section 260E.03, if the court finds that:

(1) there is a reasonable likelihood that the records in question will disclose material information or evidence of substantial value in connection with the investigation or prosecution; and

(2) there is no other practicable way of obtaining the information or evidence. This clause shall not be construed to prohibit disclosure of the patient record when it supports the otherwise uncorroborated statements of any material fact by a minor alleged to have been abused or neglected by the patient; and

(3) the actual or potential injury to the patient-health professional relationship in the treatment program affected, and the actual or potential harm to the ability of the program to attract and retain patients, is outweighed by the public interest in authorizing the disclosure sought.

No records may be disclosed under this paragraph other than the records of the specific patient suspected of the neglect or abuse of a minor. Disclosure and dissemination of any information from a patient record shall be limited under the terms of the order to assure that no information will be disclosed unnecessarily and that dissemination will be no wider than necessary for purposes of the investigation or prosecution.

Sec. 92. Minnesota Statutes 2024, section 626.5533, is amended to read:

626.5533 REPORTING POTENTIAL WELFARE FRAUD.

Subdivision 1. **Reports required.** A peace officer must report to the head of the officer's department every arrest where the person arrested possesses more than one welfare electronic benefit transfer card. Each report must include all of the following:

(1) the name of the suspect;

(2) the suspect's driver's license or state identification card number, where available;

(3) the suspect's home address;

(4) the number on each card;

(5) the name on each electronic benefit card in the possession of the suspect, in cases where the card has a name printed on it;

(6) the date of the alleged offense;

(7) the location of the alleged offense;

(8) the alleged offense; and

(9) any other information the commissioner of human services or the commissioner of children, youth, and families deems necessary.

Subd. 2. **Use of information collected.** The head of a local law enforcement agency or state law enforcement department that employs peace officers licensed under section 626.843 must forward the report required under subdivision 1 to the ~~commissioner~~ commissioners of human services and children, youth, and families within 30 days of receiving the report. The ~~commissioner~~ commissioners of human services and children, youth, and families shall use the report to determine whether the suspect is authorized to possess any of the electronic benefit cards found in the suspect's possession.

Subd. 3. **Reporting forms.** The ~~commissioner~~ commissioners of human services and children, youth, and families, in consultation with the superintendent of the Bureau of Criminal Apprehension, shall adopt reporting forms to be used by law enforcement agencies in making the reports required under this section.

Sec. 93. **REVISOR INSTRUCTION.**

The revisor of statutes must renumber Minnesota Statutes, section 299A.955, as Minnesota Statutes, section 142A.765, and make any necessary changes to statutory cross-references to reflect this change.

Sec. 94. **REVISOR INSTRUCTION.**

The revisor of statutes must move the subdivisions in Minnesota Statutes, section 142E.50, into Minnesota Statutes, section 142E.01, renumber in alphabetical order, and make any necessary changes to statutory cross-references to reflect these changes.

Sec. 95. **REPEALER.**

Minnesota Statutes 2024, sections 142A.15; 142E.50, subdivisions 2 and 12; 245A.02, subdivision 6d; 256G.02, subdivisions 3 and 5; and 261.003, are repealed.

ARTICLE 22
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 62E.23, subdivision 1, is amended to read:

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, through August 15, 2026, the association must disburse all applicable reinsurance payments to an eligible health carrier.

(h) The association must disburse applicable reinsurance payments for claims costs incurred by eligible health carriers through December 31, 2025. Reinsurance payments are not available to eligible health carriers for claims costs incurred after December 31, 2025.

Sec. 2. **[62V.15] DEFINITIONS; PREMIUM SUBSIDY PROGRAM.**

Subdivision 1. **Scope.** For purposes of sections 62V.15 to 62V.18, the following terms have the meanings given.

Subd. 2. **Assessment.** "Assessment" means the amount a health plan company must pay for operational costs, administrative costs, and premium subsidy payments for the premium subsidy program established under section 62V.16.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of management and budget.

Subd. 4. **Eligible individual.** (a) "Eligible individual" means a Minnesota resident who:

(1) is not eligible for an advance premium tax credit under Code of Federal Regulations, title 26, part 1.36B-2, in a month in which the eligible individual's coverage is effective;

(2) is not enrolled in public program coverage under chapters 256B and 256L; and

(3) purchased an individual health plan, as defined in section 62A.011.

(b) "Eligible individual" includes a person required to repay an advanced premium tax credit because the person's income was subsequently determined to exceed the maximum permissible amount to qualify as an applicable taxpayer under Code of Federal Regulations, title 26, part 1.36B-2.

Subd. 5. **Gross premium.** "Gross premium" means the amount billed for a health plan purchased by an eligible individual prior to a premium subsidy in a calendar year.

Subd. 6. **Health plan company.** "Health plan company" has the meaning given in section 62Q.01.

Subd. 7. **Net premium.** "Net premium" means the gross premium less the premium subsidy.

Subd. 8. **Premium subsidy.** "Premium subsidy" means a payment (1) made on behalf of an eligible individual to promote general welfare, and (2) that is not compensation for a service rendered.

Sec. 3. **[62V.16] PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE INDIVIDUALS.**

Subdivision 1. **Program established.** Beginning January 1, 2026, the board of directors of MNsure, in consultation with the commissioners of commerce and human services, must

establish and administer the premium subsidy program authorized by this section to help eligible individuals pay for coverage in the individual market.

Subd. 2. **Premium subsidy provided.** (a) A health carrier must provide a premium subsidy to each eligible individual who purchases an individual health plan from the health carrier. The premium subsidy must be provided for each month the net premium is paid. An eligible individual must pay the net premium amount to the health carrier.

(b) Each premium subsidy must be equal to 20 percent of the monthly gross premium otherwise paid by or on behalf of the eligible individual for coverage purchased in the individual market that covers the eligible individual and the eligible individual's spouse and dependents.

(c) The premium subsidy must be excluded from a calculation used to determine eligibility for a Department of Human Services or Department of Children, Youth, and Families program.

Subd. 3. **Payments to health carriers.** (a) The commissioner must make payments by September 30 to health carriers on behalf of eligible individuals for the months during the prior calendar year for which the individual has paid the net premium amount to the health carrier. The amount of the commissioner's payments to health carriers must be in the amounts provided to the commissioner by the board under paragraph (c). The commissioner must not withhold payment because a health carrier cannot prove an enrollee is an eligible individual.

(b) In order to be eligible for payment, a health carrier seeking reimbursement from the board must submit an invoice and supporting information to the board, using a form developed by the board. The form must require the health carrier to identify the number of eligible individuals for which the health carrier is seeking reimbursement, the average gross premium for eligible individuals, and the aggregate amount of reimbursement claimed by the health carrier for premium subsidies under this section. The board must finalize the form by November 1, 2025.

(c) The board must provide the commissioner, based on the information received by the board from the health carriers pursuant to paragraph (b), the payment amount owed to each health carrier.

(d) The board must consider a health carrier as a vendor under section 16A.124, subdivision 3, and each monthly invoice must represent the services that have been completed or delivered.

(e) The commissioner, in consultation with the board, may withhold payments and charge back payments to recover from health carriers premium subsidies provided but that do not comply with the applicable legal requirements of this section.

Subd. 4. **Assessment.** (a) An annual assessment is imposed on health plan companies for each calendar year beginning in calendar year 2026. The commissioner of commerce must establish the annual assessment for each health plan company in an amount such that the aggregate assessment amount collected from health plan companies under this subdivision equals the amount necessary for the premium subsidy program established under subdivision 1.

(b) By March 1 each year, the commissioner of commerce must consult with the board of directors of MNsure and provide each health plan company with an estimate of the company assessment for the current calendar year.

(c) By May 31 each year, the commissioner of commerce, in consultation with the board of directors of MNsure, must notify each health plan company of the company's assessment for the current calendar year.

(d) By June 30 each year, the commissioner of commerce must collect assessments from health plan companies to pay for the premium subsidy program established under this section.

Subd. 5. **Data practices.** (a) The definitions in section 13.02 apply to this subdivision.

(b) Government data on an enrollee or health carrier under this section are private data on individuals or nonpublic data, except that the total reimbursement requested by a health carrier and the total state payment to the health carrier are public data.

Sec. 4. **[62V.17] APPLICABILITY OF GROSS PREMIUM.**

Notwithstanding premium subsidies provided under section 62V.16, subdivision 2, the premium base to calculate any applicable premium taxes under chapter 297I is the gross premium for health plans purchased by eligible individuals in the individual market.

Sec. 5. **[62V.18] PREMIUM SUBSIDY PROGRAM ACCOUNT.**

Subdivision 1. **Account established.** The premium subsidy program account is created in the special revenue fund in the state treasury.

Subd. 2. **Collected assessments.** The commissioner of commerce must deposit the assessments collected under section 62V.16, subdivision 4, in the premium subsidy program account created under subdivision 1.

Subd. 3. **Appropriations.** Money in the premium subsidy program account is annually appropriated:

(1) to the commissioner of management and budget for the payments to health carriers on behalf of eligible individuals under section 62V.16, subdivision 3; and

(2) to the board of directors of MNsure for operational and administrative costs for the premium subsidy program established under section 62V.16.

Sec. 6. Minnesota Statutes 2024, section 149A.02, is amended by adding a subdivision to read:

Subd. 42. **Green burial.** "Green burial" means a method of burial that emphasizes environmental sustainability without interfering with natural decomposition and:

(1) the body is not embalmed;

(2) a biodegradable casket or shroud is used; and

(3) no vault or outer burial container is employed for a casket or shroud.

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

Sec. 7. Minnesota Statutes 2024, section 151.741, subdivision 5, is amended to read:

Subd. 5. **Insulin repayment account; annual transfer from health care access fund.** (a) The insulin repayment account is established in the special revenue fund in the state treasury. Money in the account is appropriated each fiscal year to the commissioner of administration to reimburse manufacturers for insulin dispensed under the insulin safety net program in section 151.74, in accordance with section 151.74, subdivisions 3, paragraph (h), and 6, paragraph (h), and to cover costs incurred by the commissioner in providing these reimbursement payments.

(b) By June 30, 2025, and each June 30 thereafter, the commissioner of administration shall certify to the commissioner of management and budget the total amount expended in the prior fiscal year for:

(1) reimbursement to manufacturers for insulin dispensed under the insulin safety net program in section 151.74, in accordance with section 151.74, subdivisions 3, paragraph (h), and 6, paragraph (h); and

(2) costs incurred by the commissioner of administration in providing the reimbursement payments described in clause (1).

(c) The commissioner of management and budget shall transfer from the health care access fund to the ~~special revenue fund~~ insulin repayment account, beginning July 1, 2025, and each July 1 thereafter, an amount equal to the amount to which the commissioner of administration certified pursuant to paragraph (b).

Sec. 8. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 44. **Notification of federal approval; report.** (a) For any provision over which the commissioner has jurisdiction and that has an effective date contingent upon federal approval, whether the contingency is expressed in an effective date, in the text of a statutory provision, or in the text of an uncodified section of session law, the commissioner must notify the revisor of statutes of which enacted provisions contain such contingent federal approval and when federal approval is obtained for any such provision according to paragraphs (b) and (c).

(b) By July 1 of each year, the commissioner must provide the revisor of statutes; the director of the House Research Department; and the director of Senate Counsel, Research and Fiscal Analysis with a report containing a complete list of all provisions enacted since the preceding July 1 with an effective date contingent on federal approval.

(c) By September 1 of each year, the commissioner must provide the revisor of statutes; the director of the House Research Department; and the director of Senate Counsel, Research and Fiscal Analysis with a report containing a complete list of all statutory provisions previously enacted with an effective date contingent on federal approval. The commissioner must identify in the report which, if any, provisions received federal approval since the preceding September 1 and the date that federal approval for each provision was received. If no provisions have received federal approval since the preceding September 1, the report must state that fact. The revisor of statutes may authorize the commissioner to remove federally approved provisions from subsequent reports submitted.

(d) The reports in paragraphs (b) and (c) must be provided in a form prescribed by the revisor of statutes.

(e) An employee in the Department of Human Services who is responsible for identifying and tracking federal approval of provisions must attest to the accuracy of the reports in a manner prescribed by the revisor of statutes.

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

Sec. 9. Minnesota Statutes 2024, section 256B.051, subdivision 3, is amended to read:

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;

~~(4)~~ (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

~~(5)~~ (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.

Sec. 10. **[306.991] GREEN BURIALS IN PUBLIC CEMETERIES.**

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

(b) "Drainage system" has the meaning given in section 103E.005, subdivision 12.

(c) "Green burial" has the meaning given in section 149A.02, subdivision 42.

(d) "Natural watercourse" has the meaning given in section 103G.005, subdivision 13.

(e) "Ordinary high-water level" has the meaning given in section 103G.005, subdivision 14.

(f) "Water supply well" has the meaning given in section 103I.005, subdivision 20a.

Subd. 2. **Green burial requirements.** A municipality, town, or other cemetery governed by this chapter that allows for green burials must comply with the requirements of this section.

Subd. 3. **Green burial plot locations.** (a) Green burial plots must have a designated location within the cemetery. Green burial plot locations must:

(1) be set back 50 feet from property lines;

(2) maintain at least three and one-half feet clearance above the ordinary high-water level;

(3) not be in standing water;

(4) not be within zone 1 groundwater source protection zones around a spring, water supply well, or a shaft drilled into the ground meant to extract water; and

(5) not be within flood-prone areas.

(b) Green burial plot locations must be a certain distance from water sources. Green burial plot locations must be:

(1) 50 feet from water supply wells and shafts drilled into the ground used to extract water;

(2) 100 feet from other springs or watercourses; and

(3) 33 feet from drainage systems.

Subd. 4. **Burial depth.** (a) Green burial plots must be at a minimum depth of three and one-half feet from the base of the grave to the soil horizon.

(b) Green burials must have three and one-half feet of cover.

Subd. 5. **Burial density.** Green burial plots must be a maximum of 300 burials per acre over a 100 year period.

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

Sec. 11. **[306.992] SCATTERING OF HYDROLYZED OR CREMATED REMAINS.**

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

(b) "Cremated remains" has the meaning given in section 149A.02, subdivision 7.

(c) "Hydrolyzed remains" has the meaning given in section 149A.02, subdivision 24a.

Subd. 2. **Designated location.** A municipality, town, or other cemetery governed by this chapter that allows for scattering of hydrolyzed remains or cremated remains must designate a location within the cemetery for the scattering of hydrolyzed remains or cremated remains.

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

Sec. 12. **[307.14] GREEN BURIALS IN PRIVATE CEMETERIES.**

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

(b) "Drainage system" has the meaning given in section 103E.005, subdivision 12.

(c) "Green burial" has the meaning given in section 149A.02, subdivision 42.

(d) "Natural watercourse" has the meaning given in section 103G.005, subdivision 13.

(e) "Ordinary high-water level" has the meaning given in section 103G.005, subdivision 14.

(f) "Water supply well" has the meaning given in section 103I.005, subdivision 20a.

Subd. 2. **Green burial requirements.** A person who owns a cemetery governed by this chapter that allows for green burials must comply with the requirements of this section.

Subd. 3. **Green burial plot locations.** (a) Green burial plots must have a designated location within the cemetery. Green burial plot locations must:

(1) be set back 50 feet from property lines;

(2) maintain at least three and one-half feet clearance above the ordinary high-water level;

(3) not be in standing water;

(4) not be within zone 1 groundwater source protection zones around a spring, water supply well, or a shaft drilled into the ground meant to extract water; and

(5) not be within flood-prone areas.

(b) Green burial plot locations must be a certain distance from water sources. Green burial plot locations must be:

(1) 50 feet from water supply wells and shafts drilled into the ground used to extract water;

(2) 100 feet from other springs or watercourses; and

(3) 33 feet from drainage systems.

Subd. 4. **Burial depth.** (a) Green burial plots must be at a minimum depth of three and one-half feet from the base of the grave to the soil horizon.

(b) Green burials must have three and one-half feet of cover.

Subd. 5. **Burial density.** Green burial plots must be a maximum of 300 burials per acre over a 100 year period.

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

Sec. 13. **[307.15] SCATTERING OF HYDROLYZED OR CREMATED REMAINS.**

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

(b) "Cremated remains" has the meaning given in section 149A.02, subdivision 7.

(c) "Hydrolyzed remains" has the meaning given in section 149A.02, subdivision 24a.

Subd. 2. **Designated location.** A person who owns a cemetery governed by this chapter that allows for scattering of hydrolyzed remains or cremated remains must designate a location within the cemetery for the scattering of hydrolyzed or cremated remains.

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

Sec. 14. Laws 2024, chapter 127, article 67, section 6, is amended to read:

Sec. 6. **COMMISSIONER OF MANAGEMENT AND BUDGET**

Appropriations by Fund

	2024	2025
General	-0-	(232,000)
Health Care Access	-0-	100,000

(a) **Insulin safety net program.** $100,000 in fiscal year 2025 is from the health care access fund for the insulin safety net program in Minnesota Statutes, section 151.74.

(b) **Transfer.** The commissioner must transfer from the health care access fund to the insulin ~~safety net program~~ repayment account in the special revenue fund the amount certified by

the commissioner of administration under Minnesota Statutes, section 151.741, subdivision 5, paragraph (b), estimated to be $100,000 in fiscal year 2025, for reimbursement to manufacturers for insulin dispensed under the insulin safety net program in Minnesota Statutes, section 151.74. The base for this transfer is estimated to be $100,000 in fiscal year 2026 and $100,000 in fiscal year 2027.

(c) **Base Level Adjustment.** The health care access fund base is increased by $100,000 in fiscal year 2026 and increased by $100,000 in fiscal year 2027.

Sec. 15. **TRANSFERS TO THE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES IN UNCODIFIED LAW.**

Any power, duty, or responsibility given to the commissioner of human services or the Department of Human Services in an uncodified section of Laws of Minnesota that is a part of, necessary for, or in service of a power, duty, or responsibility transferred in Laws 2023, chapter 70, article 12, section 30, or Laws 2024, chapter 80, transfers to the commissioner of children, youth, and families or the Department of Children, Youth, and Families upon the notice of transfer of the underlying power, duty, or responsibility required in Laws 2023, chapter 70, article 12, section 30, subdivision 1. This section applies to uncodified sections of Laws of Minnesota enacted before and after Laws 2023, chapter 70, including but not limited to Laws 2024, chapter 117, sections 16 to 22.

Sec. 16. **OPERATION WITHIN EXISTING RESOURCES.**

The board of directors of MNsure may, if necessary, operate and administer the premium subsidy program established under Minnesota Statutes, section 62V.16, in nonconformance with that section to the minimum extent necessary, using existing resources and available processes until January 1, 2027.

Sec. 17. **DIRECTION TO THE COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES; CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATIONS.**

(a) The commissioner of children, youth, and families shall allocate $1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 from the child care and development block grant for child care improvement grants under Minnesota Statutes, section 142D.20, subdivision 3, paragraph (a), clause (7). This is a onetime allocation.

(b) The commissioner of children, youth, and families shall allocate $55,000 in fiscal year 2026, $639,000 in fiscal year 2027, $1,639,000 in fiscal year 2028, and $1,638,000 in fiscal year 2029 from the child care and development block grant for the development of a statewide electronic attendance and record keeping system for the child care assistance program.

(c) The commissioner of children, youth, and families shall allocate $1,419,000 in fiscal year 2026, $4,221,000 in fiscal year 2027, $4,791,000 in fiscal year 2028, and $4,885,000 in fiscal year 2029 from the child care and development block grant for MFIP child care assistance to comply with federal requirements.

(d) The commissioner of children, youth, and families shall allocate $2,662,000 in fiscal year 2026, $5,479,000 in fiscal year 2027, $5,482,000 in fiscal year 2028, and $5,196,000 in fiscal year 2029 from the child care and development block grant for basic sliding fee child care assistance to comply with federal requirements.

Sec. 18. **DIRECTION TO COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES; ALLOCATION OF TANF-ELIGIBLE GENERAL FUND EXPENDITURES.**

The commissioner of children, youth, and families must identify $4,000,000 in fiscal year 2026, $4,000,000 in fiscal year 2027, $4,000,000 in fiscal year 2028, and $4,000,000 in fiscal year 2029 of general fund expenditures attributable to eligible activities under Minnesota Statutes, chapter 142G, and reduce general fund expenditures by the same amounts. The commissioner must allocate $4,000,000 in fiscal year 2026, $4,000,000 in fiscal year 2027, $4,000,000 in fiscal year 2028, and $4,000,000 in fiscal year 2029 to eligible activities under Minnesota Statutes, chapter 142G, to the TANF fund.

Sec. 19. **REVISOR INSTRUCTION.**

By February 1, 2026, the revisor of statutes must identify any changes to Minnesota Statutes and Minnesota Rules necessary to reflect the expiration of the Minnesota premium security plan and the premium security account. The revisor of statutes may submit to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce finance and policy draft legislation with the statutory changes necessary to implement the identified changes.

Sec. 20. **REPEALER.**

Minnesota Statutes 2024, sections 62E.21; 62E.22; 62E.23; 62E.24; and 62E.25, are repealed.

EFFECTIVE DATE. This section is effective August 16, 2026.

ARTICLE 23
FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2023, chapter 70, article 20, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2025" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2025.

	APPROPRIATIONS Available for the Year Ending June 30 2025
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (224,693,000)**
Appropriations by Fund	
	2025
General	(202,264,000)
Health Care Access	(17,144,000)
Federal TANF	(5,285,000)

Subd. 2. **Forecasted Programs**

(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**

	Appropriations by Fund
	2025
General	(5,238,000)
Federal TANF	(5,285,000)

(b) **MFIP Child Care Assistance** (57,918,000)

(c) **General Assistance** 1,932,000

(d) **Minnesota Supplemental Aid** 3,278,000

(e) **Housing Support** 9,569,000

(f) **Northstar Care for Children** (9,006,000)

(g) **MinnesotaCare** (16,701,000)

This appropriation is from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund
	2025
General	(155,544,000)
Health Care Access	(443,000)

(i) **Behavioral Health Fund** 10,633,000

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 24

DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of human services for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that

the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	**$ 3,271,313,000**	**$ 3,434,480,000**

Subdivision 1. **Total Appropriation**

Appropriations by Fund	2026	2027
General	1,987,159,000	2,177,961,000
State Government Special Revenue	4,273,000	4,273,000
Health Care Access	1,279,188,000	1,251,553,000
Lottery Prize	163,000	163,000
Family and Medical Benefit Insurance	530,000	530,000

The amounts that may be spent for each purpose are specified in this article.

Subd. 2. **Information Technology Appropriations**

(a) **IT appropriations generally.** This appropriation includes money for information technology projects, services, and support. Funding for information technology project costs must be incorporated into the service-level agreement and paid to Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for systems project.** Appropriations and federal receipts for

information technology systems projects for MMIS and METS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services deems necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Sec. 3. **CENTRAL OFFICE; OPERATIONS**

Subdivision 1. **Total Appropriation**	**$**	**166,091,000**	**$** **171,233,000**
Appropriations by Fund			
General		143,905,000	147,520,000
State Government Special Revenue		248,000	248,000
Health Care Access		21,408,000	22,935,000
Family and Medical Benefits Insurance		530,000	530,000

Subd. 2. **Administrative Recovery; Set-Aside**

The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) the statewide data management system authorized in Minnesota Statutes, section 125A.744, subdivision 3;

(2) repayment of the special revenue maximization account as provided under

Minnesota Statutes, section 245.495, paragraph (b);

(3) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) targeted case management under Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) residential services for children with severe emotional disturbance under Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

Subd. 3. **Family and Medical Benefit Insurance**

$530,000 each year is from the family and medical benefit insurance fund for systems costs to administer Minnesota Statutes, chapter 268B.

Subd. 4. **Base Level Adjustment**

The general fund base for this section is $148,206,000 in fiscal year 2028 and $149,166,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE**

Subdivision 1. **Total Appropriation**		**$ 69,393,000**	**$ 65,729,000**
	Appropriations by Fund		
General	41,225,000	37,561,000	
Health Care Access	28,168,000	28,168,000	

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $37,588,000 in fiscal year 2028 and $37,588,000 in fiscal year 2029.

Sec. 5. **CENTRAL OFFICE; AGING AND DISABILITY SERVICES** **$ 49,290,000 $ 49,194,000**

Appropriations by Fund

General	49,165,000	49,069,000
State Government Special Revenue	125,000	125,000

Sec. 6. **CENTRAL OFFICE; BEHAVIORAL HEALTH** **$ 22,775,000 $ 22,159,000**

Appropriations by Fund

General	22,612,000	21,996,000
Lottery Prize	163,000	163,000

Psychiatric Residential Treatment Facility Report. $500,000 in fiscal year 2026 is from the general fund for the development of the psychiatric residential treatment facility report and proposed legislation. This is a onetime appropriation and is available until June 30, 2027.

Sec. 7. **CENTRAL OFFICE; HOMELESSNESS, HOUSING, AND SUPPORT SERVICES** **$ 7,065,000 $ 6,421,000**

Sec. 8. **CENTRAL OFFICE; OFFICE OF INSPECTOR GENERAL**

Subdivision 1. **Total Appropriation** **$ 36,262,000 $ 37,456,000**

Appropriations by Fund

General	31,421,000	32,615,000
State Government Special Revenue	3,900,000	3,900,000
Health Care Access	941,000	941,000

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $32,671,000 in fiscal year 2028 and $32,617,000 in fiscal year 2029.

Sec. 9. **FORECASTED PROGRAMS; GENERAL ASSISTANCE** **$ 84,138,000 $ 86,462,000**

Emergency General Assistance

(a) The amount appropriated for emergency general assistance is up to $6,729,812 in fiscal year 2026 and up to $6,729,812 in fiscal year 2027.

(b) Money to counties for emergency general assistance shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06, subdivision 2, paragraph (c).

Sec. 10. **FORECASTED PROGRAMS; MINNESOTA SUPPLEMENTAL ASSISTANCE** **$ 67,113,000 $ 69,089,000**

Sec. 11. **FORECASTED PROGRAMS; HOUSING SUPPORT** **$ 269,258,000 $ 279,703,000**

Sec. 12. **FORECASTED PROGRAMS; MINNESOTACARE** **$ 106,426,000 $ 169,731,000**

This appropriation is from the health care access fund.

Sec. 13. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE** **$ 2,137,399,000 $ 2,219,809,000**

Appropriations by Fund

General	1,018,619,000	1,193,496,000
Health Care Access	1,118,780,000	1,026,313,000

The health care access fund base for this section is $990,107,000 in fiscal year 2028 and $999,798,000 in fiscal year 2029.

Sec. 14. **GRANT PROGRAMS; CHILD AND COMMUNITY SERVICES GRANTS** **$ 5,655,000 $ 5,655,000**

Sec. 15. **GRANT PROGRAMS; REFUGEE SERVICES GRANTS** **$ 100,000 $ 100,000**

Sec. 16. **GRANT PROGRAMS; HEALTH CARE GRANTS** **$ 8,176,000 $ 8,176,000**

Subdivision 1. **Total Appropriations**

	Appropriations by Fund	
General	4,711,000	4,711,000
Health Care Access	3,465,000	3,465,000

Subd. 2. **Legal Referral and Assistance Grants**

$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are from the general fund for legal referral and assistance grants under Minnesota Statutes, section 142A.40.

Subd. 3. **Grants for Integrated Care for High-Risk Pregnant Women**

$2,089,000 in fiscal year 2026 and $2,089,000 in fiscal year 2027 are from the general fund for grants to improve birth outcomes and strengthen early parental resilience for pregnant women who are medical assistance enrollees, are at significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations under Minnesota Statutes, section 256B.79.

Subd. 4. **MinnesotaCare Application Assistance Bonuses**

$3,115,000 in fiscal year 2026 and $3,115,000 in fiscal year 2027 are from the health care access fund for application assistance bonuses to organizations and licensed insurance producers for applicants successfully enrolled in MinnesotaCare under Minnesota Statutes, section 256.962, subdivision 5.

Subd. 5. **Medical Assistance Application Assistance Bonuses**

$320,000 in fiscal year 2026 and $320,000 in fiscal year 2027 are from the general fund for application assistance bonuses to organizations and licensed insurance producers for applicants successfully enrolled in medical assistance under Minnesota Statutes, section 256.962, subdivision 5.

Subd. 6. **Medical Assistance Application Assistance Bonuses**

$310,000 in fiscal year 2026 and $310,000 in fiscal year 2027 are from the health care access fund for application assistance bonuses to organizations and licensed insurance producers for applicants successfully enrolled in medical assistance under Minnesota Statutes, section 256.962, subdivision 5.

Subd. 7. **Medical Assistance Outreach Grants**

$90,000 in fiscal year 2026 and $90,000 in fiscal year 2027 are from the general fund for grants to public and private organizations, regional collaboratives, and regional health care outreach centers for outreach activities for medical assistance under Minnesota Statutes, section 256.962, subdivision 2.

Subd. 8. **MinnesotaCare Outreach Grants**

$40,000 in fiscal year 2026 and $40,000 in fiscal year 2027 are from the health care access fund for grants to public and private organizations, regional collaboratives, and regional health care outreach centers for outreach activities for MinnesotaCare under Minnesota Statutes, section 256.962, subdivision 2.

Subd. 9. **Grants for Periodic Data Matching for Medical Assistance and MinnesotaCare**

$2,112,000 in fiscal year 2026 and $2,112,000 in fiscal year 2027 are from the general fund for grants to counties for costs related to periodic data matching for medical assistance and MinnesotaCare recipients under Minnesota Statutes, section 256B.0561.

Sec. 17. **GRANT PROGRAMS; DISABILITIES GRANTS** **$ 1,780,000 $ 1,780,000**

Grants to Community-Based HIV/AIDS Support Services Providers. $4,000,000 in fiscal year 2026 and $4,000,000 in fiscal year 2027 are for grants to community-based HIV/AIDS support services providers.

Sec. 18. **GRANT PROGRAMS; HOUSING AND SUPPORT SERVICES GRANTS** **$ 89,570,000 $ 92,911,000**

Subdivision 1. **Family Supportive Housing Grant Program**

$700,000 in fiscal year 2026 is for the family supportive housing grant program. This is a onetime appropriation and is available until June 30, 2027.

Subd. 2. **Grant for Catholic Charities Homeless Elders Program**

$959,000 in fiscal year 2026 is for a grant to Catholic Charities of St. Paul and Minneapolis for the homeless elders program that helps homeless, isolated, and low-income older adults to move into stable housing. This is a onetime appropriation and is available until June 30, 2027.

Subd. 3. **Emergency Services Grants**

$25,000,000 in fiscal year 2026 and $30,000,000 in fiscal year 2027 are from the

general fund for emergency services grants under Minnesota Statutes, section 256K.49.

Subd. 4. **Homeless Youth Act Grants**

$15,136,000 in fiscal year 2026 and $15,136,000 in fiscal year 2027 are from the general fund for Homeless Youth Act grants under Minnesota Statutes, section 256K.45.

Subd. 5. **Safe Harbor Shelter and Housing Grants**

$1,250,000 in fiscal year 2026 and $1,250,000 in fiscal year 2027 are from the general fund for safe harbor shelter and housing grants under Minnesota Statutes, section 256K.47.

Subd. 6. **Transitional Housing Program Grants**

$3,000,000 in fiscal year 2026 and $3,000,000 in fiscal year 2027 are from the general fund for transitional housing program grants under Minnesota Statutes, section 256K.48.

Subd. 7. **Long-Term Homeless Supportive Services Grants**

$6,910,000 in fiscal year 2026 and $6,910,000 in fiscal year 2027 are from the general fund for long-term homeless supportive services grants under Minnesota Statutes, section 256K.26.

Sec. 19. **GRANT PROGRAMS; ADULT MENTAL HEALTH GRANTS** **$ 110,977,000 $ 110,977,000**

Subdivision 1. **Early Episode of Bipolar Disorder Grants**

$125,000 in fiscal year 2026 and $125,000 in fiscal year 2027 are for early episode of bipolar disorder grants under Minnesota Statutes, section 245.4905.

Subd. 2. **Cultural and Ethnic Minority Infrastructure Grants**

$2,891,000 in fiscal year 2026 and $2,891,000 in fiscal year 2027 are from the general fund for cultural and ethnic minority infrastructure grants under Minnesota Statutes, section 245.4903.

Subd. 3. **Grants for Adult Mental Health Culturally Specific Services**

$300,000 in fiscal year 2026 and $300,000 in fiscal year 2027 are from the general fund for grants to support increased availability of culturally responsive mental health services for racial and ethnic minorities by providing internship placements and clinical supervision to emerging mental health professionals under Minnesota Statutes, section 245.4661, subdivision 9.

Subd. 4. **Mental Health Provider Supervision Grant Program**

$1,500,000 in fiscal year 2026 and $1,500,000 in fiscal year 2027 are from the general fund for the mental health provider supervision grant program under Minnesota Statutes, section 245.4663.

Subd. 5. **Mobile Crisis Grants to Tribal Nations**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund for mobile crisis grants under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15), to Tribal Nations.

Subd. 6. **Adult Mental Illness Crisis Housing Assistance Program Grants**

$610,000 in fiscal year 2026 and $610,000 in fiscal year 2027 are from the general fund for

adult mental illness crisis housing assistance program grants under Minnesota Statutes, section 245.99.

Subd. 7. **Grants for Persons With Serious and Persistent Mental Illness**

$21,000,000 in fiscal year 2026 and $21,000,000 in fiscal year 2027 are from the general fund for grants to counties to establish, operate, or contract with private providers to provide services to help persons with serious and persistent mental illness under Minnesota Statutes, section 256K.10.

Subd. 8. **South Central Crisis Center Grant**

$600,000 in fiscal year 2026 and $600,000 in fiscal year 2027 are from the general fund for a grant to a community collaborative providing crisis center services in the Mankato area that are comparable to the crisis services provided prior to the closure of the Mankato Crisis Center under Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 10, paragraph (a), clause (1).

Subd. 9. **Projects for Assistance in Transition From Homelessness Program Grants**

$4,792,000 in fiscal year 2026 and $4,792,000 in fiscal year 2027 are from the general fund for projects for assistance in transition from homelessness program grants under Minnesota Statutes, section 245.991.

Subd. 10. **Transition to Community Initiative Grants**

$1,811,000 in fiscal year 2026 and $1,811,000 in fiscal year 2027 are from the general fund for transition to community initiative grants under Minnesota Statutes, section 256.478.

Sec. 20. **GRANT PROGRAMS; CHILD MENTAL HEALTH GRANTS** **$ 37,625,000 $ 35,675,000**

Subdivision 1. **Grant to Mental Health Collaboration Hub Innovation Pilot Program**

$750,000 in fiscal year 2026 is for a grant to the Mental Health Collaboration Hub for the Mental Health Collaboration Hub innovation pilot program. This is a onetime appropriation and is available until June 30, 2027.

Subd. 2. **Psychiatric Residential Treatment Start-Up and Capacity-Building Grants**

$200,000 in fiscal year 2026 is for a grant to Clay County under Minnesota Statutes, section 256B.0941, subdivision 5, for a new 18-bed psychiatric residential treatment facility in Clay County. This is a onetime appropriation and is available until June 30, 2029.

Subd. 3. **Grant to Clay County for Psychiatric Residential Treatment Facility**

$1,000,000 in fiscal year 2026 is for a grant to Clay County for the purchase of equipment and final redesign and remodeling for the conversion of the West Central Regional Juvenile Center nonsecure unit into an 18-bed psychiatric residential treatment facility for persons younger than 21 years of age, under Minnesota Statutes, section 256B.0941. This is a onetime appropriation.

Subd. 4. **Adverse Childhood Experience Grants**

$363,000 in fiscal year 2026 and $363,000 in fiscal year 2027 are from the general fund for grants to provide training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma under Minnesota

Statutes, section 245.4889, subdivision 1, paragraph (b), clause (13).

Subd. 5. **Children's Mental Health Screening Grants**

$4,412,000 in fiscal year 2026 and $4,412,000 in fiscal year 2027 are from the general fund for grants to county child welfare agencies and juvenile justice agencies for children's mental health screening and follow-up diagnostic assessment and treatment under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (7).

Subd. 6. **Early Intervention Capacity Grants**

$1,024,000 in fiscal year 2026 and $1,024,000 in fiscal year 2027 are from the general fund for grants to provider agencies for building evidence-based mental health intervention capacity for children from birth to age five under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (10).

Subd. 7. **Cultural and Ethnic Minority Mental Health Grants**

$300,000 in fiscal year 2026 and $300,000 in fiscal year 2027 are from the general fund for grants to provider agencies for mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (6).

Subd. 8. **Evidence-Based Practices Grants**

$750,000 in fiscal year 2026 and $750,000 in fiscal year 2027 are from the general fund for

services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (8).

Subd. 9. **Person-Centered Discharge Planning Grants**

$250,000 in fiscal year 2026 and $250,000 in fiscal year 2027 are from the general fund for grants to develop and support a person-centered discharge planning process for adults and children being discharged from psychiatric residential treatment facilities, child and adolescent behavioral health hospitals, and hospital settings under Laws 2022, chapter 99, article 3, section 14, paragraph (b).

Subd. 10. **Early Childhood Mental Health Consultation Grants**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund for early childhood mental health consultation under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (15).

Subd. 11. **Mental Health First Aid Training Grants**

$23,000 in fiscal year 2026 and $23,000 in fiscal year 2027 are from the general fund for grants for mental health first aid training under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (12).

Subd. 12. **First Episode of Psychosis Grants**

$1,651,000 in fiscal year 2026 and $1,651,000 in fiscal year 2027 are from the general fund for grants to provide evidence-based

interventions for youth at risk of developing or experiencing a first episode of psychosis under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (16).

Subd. 13. **Suicide Prevention and Counseling Text Message Grants**

$1,125,000 in fiscal year 2026 and $1,125,000 in fiscal year 2027 are from the general fund for suicide prevention and counseling services that use text messaging statewide under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (11).

Subd. 14. **School-Linked Behavioral Health Grants**

$2,750,000 in fiscal year 2026 and $2,750,000 in fiscal year 2027 are from the general fund for school-linked behavioral health grants under Minnesota Statutes, section 245.4901.

Subd. 15. **Shelter-Linked Behavioral Health Grants**

$2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are from the general fund for shelter-linked behavioral health grants under Minnesota Statutes, section 256K.46.

Sec. 21. **GRANT PROGRAMS; OPERATIONS GRANTS** **$ 2,220,000 $ 2,220,000**

Fraud Prevention Investigation Grants.

$3,018,000 in fiscal year 2026 and $3,018,000 in fiscal year 2027 are from the general fund for fraud prevention investigation grants under Minnesota Statutes, section 256.983.

Sec. 22. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the advance approval of the commissioner of management and budget, may transfer unencumbered appropriation

balances for the biennium ending June 30, 2027, within fiscal years among general assistance, medical assistance, MinnesotaCare, the Minnesota supplemental aid program, the housing support program, and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioner deems necessary, with the advance approval of the commissioner of management and budget. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Subd. 3. **Temporary authority for interagency transfers with Department of Children, Youth, and Families.** Beginning July 1, 2025, and until September 30, 2025, administrative money may be transferred between the Department of Human Services and Department of Children, Youth, and Families as the commissioners deem necessary, with the advance approval of the commissioner of management and budget. The commissioners shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over children and families quarterly about transfers made under this section.

Sec. 23. **CANCELLATIONS.**

Subdivision 1. **School-linked behavioral health grants.** $3,000,000 of the fiscal year 2025 general fund appropriation in Laws 2024, chapter 127, article 67, section 2, subdivision 9, paragraph (a), is canceled to the general fund.

Subd. 2. **New American legal, social services, and long-term care workforce grant program.** $7,000,000 of the fiscal year 2024 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 25, is canceled to the general fund.

Subd. 3. **Mobile crisis grants.** $1,672,000 of the fiscal year 2025 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 29, paragraph (e), is canceled to the general fund.

Subd. 4. **Child mental health grants.** $250,000 of the fiscal year 2025 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 30, is canceled to the general fund.

Subd. 5. **Emergency medical assistance legal referral costs.** $100,000 of the 2025 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 26, is canceled to the general fund.

Subd. 6. **Grants to navigators.** $800,000 of the fiscal year 2024 health care access fund appropriation in Laws 2023, chapter 22, section 4, subdivision 2, is canceled to the health care access fund.

Subd. 7. **Mille Lacs Band of Ojibwe American Indian child welfare initiative.** $5,294,000 of the fiscal year 2025 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 22, paragraph (b), is canceled to the general fund.

Subd. 8. **Transition grant program.** $293,000 of the fiscal year 2024 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 20, paragraph (b), is canceled to the general fund.

Subd. 9. **Grant to administer pool of qualified individuals for assessments.** $250,000 of the fiscal year 2025 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 22, paragraph (k), is canceled to the general fund.

Subd. 10. **IT systems improvements for children and families.** $10,000,000 of the fiscal year 2024 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 4, paragraph (g), is canceled to the general fund.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from June 30, 2025, whichever is earlier.

Sec. 24. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 25. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires June 30, 2027, unless a different expiration date is explicit or an appropriation is made available beyond June 30, 2027.

Sec. 26. Laws 2023, chapter 70, article 20, section 2, subdivision 30, is amended to read:

Subd. 30. **Grant Programs; Child Mental Health Grants**		44,487,000	~~37,934,000~~ 37,734,000

(a) **Psychiatric residential treatment facility start-up grants.** $1,000,000 in fiscal year 2024 and ~~$1,000,000~~ $800,000 in fiscal year 2025 are for psychiatric residential treatment facility start-up grants under Minnesota Statutes, section 256B.0941, subdivision 5. This is a onetime appropriation and is available until June 30, 2027.

(b) **African American Child Wellness Institute.** $2,000,000 in fiscal year 2024 is for a grant to the African American Child Wellness Institute to provide culturally specific mental health and substance use disorder services under Minnesota Statutes, section 245.0961. This is a onetime appropriation and is available until June 30, 2027.

(c) **Base level adjustment.** The general fund base is $34,648,000 in fiscal year 2026 and $34,648,000 in fiscal year 2027.

ARTICLE 25

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES APPROPRIATIONS

Section 1. **CHILDREN, YOUTH, AND FAMILIES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

APPROPRIATIONS

Available for the Year

	Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES**	**$ 1,351,499,000**	**$ 1,417,679,000**

Appropriations by Fund

	2026	2027
General	1,047,846,000	1,093,564,000
State Government Special Revenue	732,000	732,000
Federal TANF	302,921,000	323,383,000

The amounts that may be spent for each purpose are specified in the following sections.

Sec. 3. **TANF MAINTENANCE OF EFFORT**

Subdivision 1. **Nonfederal Expenditures**

The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF maintenance of effort requirements, the commissioner may report as TANF maintenance of effort expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 142G;

(2) the child care assistance programs under Minnesota Statutes, sections 142E.04 and 142E.08, and county child care administrative costs under Minnesota Statutes, section 142E.02, subdivision 9;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 142G and 256K;

(4) state, county, and Tribal MFIP employment services under Minnesota Statutes, chapters 142G and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671, and child tax credit expenditures under Minnesota Statutes, section 290.0661;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 142D.12.

Subd. 2. **Nonfederal Expenditures; Reporting**

For the activities listed in subdivision 1, clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

Subd. 3. **Supplemental Expenditures**

The commissioner may supplement the maintenance of effort claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this section.

Subd. 4. **Reduction of Appropriations; Exception**

The requirement in Minnesota Statutes, section 142A.06, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law does not apply if the grants or aids are federal TANF funds.

Subd. 5. **IT Appropriations Generally**

This appropriation includes funds for information technology projects, services, and support. Funding for information technology project costs must be incorporated into the service level agreement and paid to Minnesota IT Services by the Department of Children, Youth, and Families under the rates and mechanism specified in that agreement.

Subd. 6. **Receipts for Systems Project**

Appropriations and federal receipts for information technology systems projects for MAXIS, PRISM, ISDS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 142A.04. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of children, youth, and families considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Subd. 7. **Federal SNAP Education and Training Grants**

Federal funds available during fiscal years 2026 and 2027 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This subdivision is effective the day following final enactment.

Sec. 4. **OPERATIONS AND ADMINISTRATION; AGENCY-WIDE SUPPORTS**

Subdivision 1. **Total Appropriation** **$ 108,490,000 $ 101,268,000**

Appropriations by Fund

	2026	2027
General	107,658,000	102,100,000
State Government Special Revenue	732,000	732,000
Federal TANF	100,000	100,000

Subd. 2. **Information Technology**

$10,000,000 in fiscal year 2026 is from the general fund for information technology improvements to SSIS. This is a onetime appropriation.

Subd. 3. **Child Welfare Fiscal Analysis**

$250,000 in fiscal year 2026 is from the general fund to contract with a third-party consultant to conduct an independent fiscal analysis of the child welfare system in Minnesota. This is a onetime appropriation and is available until June 30, 2029.

Subd. 4. **Base Level Adjustment**

The general fund base for this section is $101,100,000 in fiscal year 2028 and $101,100,000 in fiscal year 2029.

Sec. 5. **OPERATIONS AND ADMINISTRATION; CHILD SAFETY AND PERMANENCY** **$ 17,232,000 $ 16,945,000**

Sec. 6. **OPERATIONS AND ADMINISTRATION; EARLY CHILDHOOD** **$ 17,166,000 $ 12,698,000**

Subdivision 1. **Child Care Attendance and Record-Keeping System**

$5,500,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are to develop a statewide electronic attendance and record-keeping system for the child care assistance program. The base for this appropriation is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Subd. 2. **Base Level Adjustment**

The general fund base for this section is $11,698,000 in fiscal year 2028 and $11,698,000 in fiscal year 2029.

Sec. 7. **OPERATIONS AND ADMINISTRATION; ECONOMIC OPPORTUNITY AND YOUTH SERVICES** **$ 4,110,000 $ 3,562,000**

Scan of and Report on Out-of-School and Youth Programming. $402,000 in fiscal year 2026 is to conduct the scan of and prepare the out-of-school and youth programming report. This is a onetime appropriation.

Sec. 8. **OPERATIONS AND ADMINISTRATION; FAMILY WELL-BEING** **$ 14,147,000 $ 14,147,000**

Appropriations by Fund

	2026	2027
General	10,471,000	10,471,000
Federal TANF	3,676,000	3,676,000

Sec. 9. **FORECASTED PROGRAMS; MFIP/DWP** **$ 230,473,000 $ 268,167,000**

Appropriations by Fund

	2026	2027
General	99,272,000	116,504,000
Federal TANF	131,201,000	151,663,000

Sec. 10. **FORECASTED PROGRAMS; MFIP CHILD CARE ASSISTANCE** **$ 100,244,000 $ 137,333,000**

Sec. 11. **FORECASTED PROGRAMS; NORTHSTAR CARE FOR CHILDREN** **$ 110,214,000 $ 116,160,000**

Sec. 12. **GRANT PROGRAMS; SUPPORT SERVICES GRANTS** **$ 111,359,000 $ 111,359,000**

Subdivision 1. **Total Appropriations**

Appropriations by Fund

	2026	2027
General	14,908,000	14,908,000
Federal TANF	96,451,000	96,451,000

Subd. 2. **MFIP Consolidated Fund Grants**

$8,715,000 in fiscal year 2026 and $8,715,000 in fiscal year 2027 are from the general fund for MFIP consolidated fund grants under Minnesota Statutes, section 142G.76.

Subd. 3. **Fraud Prevention Investigation Grants**

$1,768,000 in fiscal year 2026 and $1,768,000 in fiscal year 2027 are from the general fund for fraud prevention investigation grants to counties under Minnesota Statutes, section 256.983.

Subd. 4. **Injury Protection for Work Experience Participants Grants**

$10,000 in fiscal year 2026 and $10,000 in fiscal year 2027 are from the general fund for grants for injury protection for work experience participants under Minnesota Statutes, section 142G.62.

Sec. 13. **GRANT PROGRAMS; BASIC SLIDING FEE CHILD ASSISTANCE CARE GRANTS** **$ 137,768,000 $ 135,212,000**

Sec. 14. **GRANT PROGRAMS; CHILD CARE DEVELOPMENT GRANTS** **$ 139,120,000 $ 138,819,000**

Subdivision 1. **St. Cloud Area School District Preschool Programs Grant**

$301,000 in fiscal year 2026 is for a grant to Independent School District No. 742 for the Preschool 4 Success program operated with the Rotary Club of St. Cloud. This is a onetime appropriation and is available until June 30, 2027.

Subd. 2. **Family, Friend, and Neighbor Grant Program**

$2,225,000 in fiscal year 2026 and $2,225,000 in fiscal year 2027 are from the general fund for the family, friend, and neighbor grant program under Minnesota Statutes, section 142D.24.

Subd. 3. **Grants for Child Care Resource and Referral Programs**

$1,007,000 in fiscal year 2026 and $1,007,000 in fiscal year 2027 are from the general fund for grants to organizations operating child care resource and referral programs under Minnesota Statutes, section 142E.31.

Subd. 4. **Child Care Workforce Development Grants Administration**

$1,300,000 in fiscal year 2026 and $1,300,000 in fiscal year 2027 are from the general fund for a grant to the statewide child care resource and referral network to administer child care workforce development grants under Minnesota Statutes, section 142E.31, subdivision 5, clause (10).

Subd. 5. **Great Start Compensation Support Payments**

$129,887,000 in fiscal year 2026 and $129,887,000 in fiscal year 2027 are from the general fund for the great start compensation support payments under Minnesota Statutes, section 142D.21.

Subd. 6. **Teacher Education and Compensation Helps Grants**

$695,000 in fiscal year 2026 and $695,000 in fiscal year 2027 are from the general fund for teacher education and compensation helps (TEACH) grants under Minnesota Statutes, section 142D.31.

Subd. 7. **Early Childhood Registered Apprenticeship Grant Program**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund for early childhood registered apprenticeship grants under Minnesota Statutes, section 142D.32.

Subd. 8. **Retaining Early Educators Through Attaching Incentives Now (REETAIN) Grant Program**

$750,000 in fiscal year 2026 and $750,000 in fiscal year 2027 are from the general fund for REETAIN grants under Minnesota Statutes, section 142D.30.

Sec. 15. **GRANT PROGRAMS; CHILD SUPPORT ENFORCEMENT GRANTS** **$ 50,000 $ 50,000**

Sec. 16. **GRANT PROGRAMS; CHILDREN'S SERVICES GRANTS** **$ 41,704,000 $ 41,705,000**

Subdivision 1. **Restorative Practices Initiatives Grants**

The base funding for restorative practices initiatives grants under Minnesota Statutes,

section 142A.76, subdivision 5, is reduced by $1,500,000 in fiscal year 2026 and $1,500,000 in fiscal year 2027.

Subd. 2. **Fostering Connections to Success and Increasing Adoptions Act**

The commissioner shall allocate funds from the state's savings from the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance as required in Minnesota Statutes, section 142A.61, and as allowable under federal law. Additional savings to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network and as allowable under federal law.

Subd. 3. **Indian Child Welfare Grants**

$6,122,000 in fiscal year 2026 and $6,122,000 in fiscal year 2027 are from the general fund for Indian child welfare grants under Minnesota Statutes, section 260.785.

Subd. 4. **Family First Prevention Services Act Support and Development Grants**

$4,100,000 in fiscal year 2026 and $4,100,000 in fiscal year 2027 are from the general fund for family first prevention services act support and development grants under Minnesota Statutes, section 142A.45.

Subd. 5. **Family First Prevention Services Act Kinship Navigator Program Grants**

$506,000 in fiscal year 2026 and $507,000 in fiscal year 2027 are from the general fund for

family first prevention services act kinship navigator program grants under Minnesota Statutes, section 142A.451.

Subd. 6. **Family First Prevention Services Act Prevention and Early Intervention Allocation Grants**

$6,000,000 in fiscal year 2026 and $6,000,000 in fiscal year 2027 are from the general fund for family first prevention services act prevention and early intervention allocation grants under Minnesota Statutes, section 142A.452.

Subd. 7. **Grants for Court-Appointed Counsel in Child Protection Proceedings**

$520,000 in fiscal year 2026 and $520,000 in fiscal year 2027 are from the general fund for county costs, including administrative costs to obtain Title IV-E federal reimbursement, related to court-appointed counsel in child protection proceedings pursuant to Minnesota Statutes, section 260C.163, subdivision 3, under Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 22, paragraph (b).

Subd. 8. **Quality Parenting Initiative Grants**

$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are from the general fund for a grant to Quality Parenting Initiative Minnesota for quality parenting initiative grants under Minnesota Statutes, section 245.0962.

Subd. 9. **Child Protection Grants to Address Child Welfare Disparities**

$1,650,000 in fiscal year 2026 and $1,650,000 in fiscal year 2027 are from the general fund

for child protection grants to address child welfare disparities under Minnesota Statutes, section 142A.417.

Subd. 10. **Grants for American Indian Child Welfare Projects**

$32,901,000 in fiscal year 2026 and $32,901,000 in fiscal year 2027 are from the general fund for grants for American Indian child welfare projects under Minnesota Statutes, section 142A.03, subdivision 9.

Subd. 11. **Grant for the White Earth Band of Ojibwe Human Services Project**

$1,400,000 in fiscal year 2026 and $1,400,000 in fiscal year 2027 are from the general fund for a grant to the White Earth Band of Ojibwe for the direct implementation and administrative costs of the White Earth Band of Ojibwe human services project under Laws 2011, First Special Session chapter 9, article 9, section 18.

Subd. 12. **Grant for Red Lake Nation Human Services Initiative Project**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for a grant to the Red Lake Nation for the direct implementation and administrative costs of the Red Lake human services initiative project authorized under Minnesota Statutes, sections 256.01, subdivision 2, paragraph (a), clause (7), and 142A.03, subdivision 2, paragraph (e), clause (7).

Subd. 13. **African American and Disproportionately Represented Family Preservation Grants**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund for African American and disproportionately represented family preservation grants under Minnesota Statutes, section 260.693.

Subd. 14. **African American Family Preservation and Child Welfare Disproportionality Act**

$3,251,000 in fiscal 2026 and $3,110,000 in fiscal year 2027 are from the general fund for the commissioner of children, youth, and families to implement the African American Family Preservation and Child Welfare Disproportionality Act under Minnesota Statutes, sections 260.61 to 260.693.

Sec. 17. **GRANT PROGRAMS; CHILD AND COMMUNITY SERVICE GRANTS** **$ 87,984,000 $ 87,984,000**

Subdivision 1. **Child Welfare Allocation Grants**

$23,870,000 in fiscal year 2026 and $23,870,000 in fiscal year 2027 are from the general fund for child welfare allocation grants under Minnesota Statutes, section 256M.41.

Subd. 2. **Opiate Epidemic Response Fund Child Protection Grants**

$3,243,000 in fiscal year 2026 and $3,243,000 in fiscal year 2027 are from the general fund for opiate epidemic response fund child protection grants under Minnesota Statutes, section 256.043, subdivision 3, paragraph (m).

Subd. 3. **Child Welfare Staff Allocation for Tribes**

$799,000 in fiscal year 2026 and $799,000 in fiscal year 2027 are from the general fund for

grants to Tribes for child welfare staffing under Minnesota Statutes, section 260.786.

Sec. 18. **GRANT PROGRAMS; CHILD AND ECONOMIC SUPPORT GRANTS** **$ 18,216,000** **$ 18,216,000**

Subdivision 1. **Regional Food Bank Grants**

$3,000,000 in fiscal year 2026 and $3,000,000 in fiscal year 2027 are for regional food bank grants under Minnesota Statutes, section 142F.16. This is a onetime appropriation and is available until June 30, 2027.

Subd. 2. **Minnesota Food Shelf Program**

$2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are for food shelf programs grants under Minnesota Statutes, section 142F.14. This is a onetime appropriation and is available until June 30, 2027.

Subd. 3. **Prepared Meals Food Relief Grants**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are for prepared meals food relief grants under Minnesota Statutes, section 142F.141. This is a onetime appropriation and is available until June 30, 2027.

Subd. 4. **Financial Assistance for Community Action Agencies**

$4,928,000 in fiscal year 2026 and $4,928,000 in fiscal year 2027 are from the general fund for community action grants under Minnesota Statutes, section 142F.30.

Subd. 5. **Family Assets for Independence Grants**

$325,000 in fiscal year 2026 and $325,000 in fiscal year 2027 are from the general fund for family assets for independence grants under Minnesota Statutes, section 142F.20.

Subd. 6. **Diaper Distribution Grants**

$553,000 in fiscal year 2026 and $553,000 in fiscal year 2027 are from the general fund for diaper distribution grants under Minnesota Statutes, section 142A.42.

Subd. 7. **Supplemental Nutrition Assistance Outreach Program Grants**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for supplemental nutrition assistance outreach program grants under Minnesota Statutes, section 142F.12.

Subd. 8. **Minnesota Food Assistance Program Grants**

$1,675,000 in fiscal year 2026 and $1,675,000 in fiscal year 2027 are from the general fund for Minnesota food assistance program grants under Minnesota Statutes, section 142F.13.

Subd. 9. **American Indian Food Sovereignty Funding Program Grants**

$2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are from the general fund for American Indian food sovereignty funding program grants under Minnesota Statutes, section 142F.15.

Subd. 10. **Food Shelf Grants**

$4,318,000 in fiscal year 2026 and $4,318,000 in fiscal year 2027 are from the general fund for food shelf grants under Minnesota Statutes, section 142F.14.

Subd. 11. **Base Level Adjustment**

The general fund base for this section is $12,216,000 in fiscal year 2028 and $12,216,000 in fiscal year 2029.

Sec. 19. **GRANT PROGRAMS; EARLY LEARNING GRANTS** **$ 132,838,000 $ 132,838,000**

Subdivision 1. **Early Childhood Literacy Programs**

The base funding for early childhood literacy programs under Minnesota Statutes, section 142D.12, subdivision 3, is reduced by $7,950,000 in fiscal year 2026 and $7,950,000 in fiscal year 2027.

Subd. 2. **Grants for Early Learning Scholarships**

$97,290,000 in fiscal year 2026 and $97,290,000 in fiscal year 2027 are from the general fund for early learning scholarships grants under Minnesota Statutes, section 142D.25.

Subd. 3. **Early Childhood Family Education Grants**

$39,779,000 in fiscal year 2026 and $41,444,000 in fiscal year 2027 are from the general fund for early childhood family education grants under Minnesota Statutes, section 142D.11.

Subd. 4. **Early Childhood Literacy Program Grants**

$7,950,000 in fiscal year 2026 and $7,950,000 in fiscal year 2027 are from the general fund for early childhood literacy program grants under Minnesota Statutes, section 142D.12.

Subd. 5. **Grants for Grow Your Own Early Childhood and Family Educator Programs**

$325,000 in fiscal year 2025 and $325,000 in fiscal year 2027 are from the general fund for grants for grow your own early childhood and family educator programs under Minnesota Statutes, section 142D.33.

Subd. 6. **Head Start Program Grants**

$34,398,000 in fiscal year 2026 and $34,398,000 in fiscal year 2027 are from the general fund for head start program grants under Minnesota Statutes, section 142D.12.

Subd. 7. **School Readiness Plus Program Grants**

$900,000 in fiscal year 2026 and $900,000 in fiscal year 2027 are from the general fund for school readiness plus program grants under Minnesota Statutes, section 142D.07.

Subd. 8. **Reach Out and Read Minnesota Grant**

$250,000 in fiscal year 2026 and $250,000 in fiscal year 2027 are for a grant to Reach Out and Read Minnesota to establish a statewide plan that encourages early childhood development through a network of health care clinics under Laws 2023, chapter 54, section 20, subdivision 20.

Subd. 9. **Grants for School Readiness Programs**

$33,683,000 in fiscal year 2026 and $33,683,000 in fiscal year 2027 are from the general fund for grants for school readiness programs under Minnesota Statutes, section 142D.05.

Sec. 20. **GRANT PROGRAMS; YOUTH SERVICES GRANTS** **$ 8,891,000 $ 8,891,000**

Subdivision 1. **Grants-in-Aid to Youth Intervention Programs**

$6,391,000 in fiscal year 2026 and $6,391,000 in fiscal year 2027 are from the general fund for grants to youth intervention programs under Minnesota Statutes, section 142A.43.

Subd. 2. **Office of Restorative Practices**

$2,500,000 in fiscal year 2026 and $2,500,000 in fiscal year 2027 are from the general fund for the Office of Restorative Practices under Minnesota Statutes, section 142A.76.

Sec. 21. **TECHNICAL ACTIVITIES** **$ 71,493,000 $ 71,493,000**

This appropriation is from the federal TANF fund.

Sec. 22. **TRANSFERS.**

Subdivision 1. **Programs and grants.** The commissioner of children, youth, and families, with the advance approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2027, within fiscal years among MFIP; MFIP child care assistance under Minnesota Statutes, section 142E.08; the entitlement portion of Northstar Care for Children under Minnesota Statutes, sections 142A.60 to 142A.612; and early childhood family education under Minnesota Statutes, section 142D.11, between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over children and families finance and policy quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Children, Youth, and Families as the commissioner deems necessary, with the advance approval of the commissioner of management and budget. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over children and families finance quarterly about transfers made under this subdivision.

Subd. 3. **Temporary authority for interagency transfers with Department of Human Services.** Beginning July 1, 2025, and until September 30, 2025, administrative money may be transferred between the Department of Children, Youth, and Families and Department of Human Services or the Department of Education as the commissioners deem necessary, with the advance approval of the commissioner of management and budget. The commissioners shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over children and families finance and policy quarterly about transfers made under this subdivision.

Sec. 23. **CANCELLATION; ESTABLISHING THE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES.**

$8,500,000 of the fiscal year 2024 general fund appropriation in Laws 2023, chapter 70, article 20, section 12, paragraph (b), is canceled to the general fund.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from June 30, 2025, whichever is earlier.

Sec. 24. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 25. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires June 30, 2027, unless a different expiration date is explicit or an appropriation is made available beyond June 30, 2027.

ARTICLE 26

DEPARTMENT OF HEALTH APPROPRIATIONS

Section 1. **HEALTH APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of health for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

		APPROPRIATIONS	
		Available for the Year	
		Ending June 30	
		2026	**2027**
Sec. 2. **COMMISSIONER OF HEALTH**	**$**	**434,678,000**	**$** **431,109,000**

Appropriations by Fund

	2026	2027
General	271,963,000	269,808,000

State Government		
Special Revenue	96,237,000	95,769,000
Health Care Access	54,765,000	53,819,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in this article.

Sec. 3. **HEALTH IMPROVEMENT**

Subdivision 1. **Total Appropriation** **$ 291,695,000 $ 286,591,000**

Appropriations by Fund

General	217,370,000	214,658,000
State Government		
Special Revenue	9,258,000	9,258,000
Health Care Access	53,354,000	50,962,000
Federal TANF	11,713,000	11,713,000

Subd. 2. **Substance Use Treatment, Recovery, and Prevention Grants**

$3,000,000 in fiscal year 2026 and $3,000,000 in fiscal year 2027 are from the general fund for substance use treatment, recovery, and prevention grants under Minnesota Statutes, section 342.72.

Subd. 3. **Local and Tribal Public Health Cannabis Grants**

$7,756,000 in fiscal year 2026 and $7,756,000 in fiscal year 2027 are from the general fund for grants under Minnesota Statutes, section 144.197, subdivision 4.

Subd. 4. **Cannabis and Substance Misuse Prevention and Education Programs; Youth Prevention and Education Program**

$5,000,000 in fiscal year 2026 and $5,000,000 in fiscal year 2027 are from the general fund for the youth prevention and education program under the cannabis and substance misuse prevention and education programs

under Minnesota Statutes, section 144.197, subdivision 1.

Subd. 5. **Cannabis and Substance Misuse Prevention and Education Programs; Prevention and Education Program for Pregnant and Breastfeeding Individuals and Individuals Who May Become Pregnant**

$2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are from the general fund for the prevention and education program for pregnant and breastfeeding individuals and individuals who may become pregnant under the cannabis and substance misuse prevention and education programs under Minnesota Statutes, section 144.197, subdivision 2.

Subd. 6. **Cannabis and Substance Misuse Prevention and Education Programs; Local and Tribal Health Departments**

$10,000,000 in fiscal year 2026 and $10,000,000 in fiscal year 2027 are from the general fund for the local and Tribal health departments under the cannabis and substance misuse prevention and education programs under Minnesota Statutes, section 144.197, subdivision 4.

Subd. 7. **Cannabis Data Collection and Biennial Reports**

$493,000 in fiscal year 2026 and $493,000 in fiscal year 2027 are from the general fund for cannabis data collection and biennial reports under Minnesota Statutes, section 144.196.

Subd. 8. **Administration of Expungement Orders**

$71,000 in fiscal year 2026 and $71,000 in fiscal year 2027 are from the general fund for the administration of expungement orders

under Laws 2023, chapter 63, article 9, section 10, subdivision 6.

Subd. 9. **Minnesota Poison Information Centers; Establishment**

$810,000 in fiscal year 2026 and $810,000 in fiscal year 2027 are from the general fund for Minnesota poison information centers under Minnesota Statutes, section 145.93.

Subd. 10. **Testing**

$690,000 in fiscal year 2026 and $690,000 in fiscal year 2027 are from the general fund for testing under Laws 2023, chapter 63, article 9, section 10, subdivision 9.

Subd. 11. **Sexual and Reproductive Health Services Grants**

$11,550,000 in fiscal year 2026 and $11,550,000 in fiscal year 2027 are from the general fund for sexual and reproductive health services grants under Minnesota Statutes, section 145.925.

Subd. 12. **Fetal Alcohol Syndrome Effects; Drug-Exposed Infant**

$3,222,000 in fiscal year 2026 and $3,222,000 in fiscal year 2027 are from the general fund for fetal alcohol syndrome effects for drug exposed infant grants under Minnesota Statutes, section 145.9265.

Subd. 13. **Fetal Alcohol Spectrum Disorders**

$..... in fiscal year 2026 and $..... in fiscal year 2027 are from the general fund for fetal alcohol spectrum disorders grants under Minnesota Statutes, section 145.267.

Subd. 14. **Hearing Aid Loan Bank Grants**

$69,000 in fiscal year 2026 and $69,000 in fiscal year 2027 are from the general fund for hearing aid loan bank grants.

Subd. 15. **Special Health Needs Grants**

$160,000 in fiscal year 2026 and $160,000 in fiscal year 2027 are from the general fund for special health needs grants.

Subd. 16. **Minnesota Birth Defects Information System**

$432,000 in fiscal year 2026 and $432,000 in fiscal year 2027 are from the general fund for the Minnesota birth defects information system under Minnesota Statutes, section 145.2215.

Subd. 17. **Early Hearing Detection and Intervention Program; Support Services for Families**

$590,000 in fiscal year 2026 and $590,000 in fiscal year 2027 are from the general fund for the early hearing detection and intervention programs; support services for families, direct hearing loss specific parent-to-parent assistance under Minnesota Statutes, section 144.966, subdivision 3a, paragraph (a), clause (1).

Subd. 18. **Early Hearing Detection and Intervention Program; Support Services for Families**

$156,000 in fiscal year 2026 and $156,000 in fiscal year 2027 are from the general fund for the early hearing detection and intervention programs; support services for families, individualized deaf or hard-of-hearing mentors who provide education under Minnesota

Statutes, section 144.966, subdivision 3a, paragraph (a), clause (2).

Subd. 19. **Nurse-Family Partnership Programs**

$2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are from the general fund for the nurse-family partnership programs under Minnesota Statutes, section 145A.145.

Subd. 20. **Home Visiting for Pregnant Women and Families with Young Children**

$15,345,000 in fiscal year 2026 and $15,345,000 in fiscal year 2027 are from the general fund for home visiting for pregnant women and families with young children under Minnesota Statutes, section 145.87.

Subd. 21. **Improving Infant Health Grants**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund for improving infant health grants under Minnesota Statutes, section 145.9574, subdivision 2.

Subd. 22. **Developmental and Social-Emotional Screening with Follow-Up**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for developmental and social-emotional screening with follow-up under Minnesota Statutes, section 145.9575.

Subd. 23. **Promising Practice Home Visiting Program**

$1,800,000 in fiscal year 2026 and $1,800,000 in fiscal year 2027 are from the general fund for the promising practice home visiting program under Minnesota Statutes, section 145.87, subdivision 1, paragraph (e).

Subd. 24. **School-Based Health Centers**

$2,300,000 in fiscal year 2026 and $2,300,000 in fiscal year 2027 are from the general fund for school-based health centers under Minnesota Statutes, section 145.903.

Subd. 25. **Comprehensive Drug Overdose and Morbidity Prevention Act**

$370,000 in fiscal year 2026 and $370,000 in fiscal year 2027 are from the general fund for the comprehensive drug overdose and morbidity prevention act under Minnesota Statutes, section 144.0528.

Subd. 26. **Local Public Health Grant**

$28,665,000 in fiscal year 2026 and $28,665,000 in fiscal year 2027 are from the general fund for local public health grants under Minnesota Statutes, section 145A.131.

Subd. 27. **Tobacco Use Prevention**

$4,921,000 in fiscal year 2026 and $4,921,000 in fiscal year 2027 are from the general fund for tobacco use prevention under Minnesota Statutes, section 144.396.

Subd. 28. **Public Health Infrastructure Funds**

$6,000,000 in fiscal year 2026 and $6,000,000 in fiscal year 2027 are from the general fund for public health infrastructure funds under Laws 2023, chapter 70, article 20, section 20, subdivision 2, paragraph (d).

Subd. 29. **Funding Formula for Community Health Boards**

$9,844,000 in fiscal year 2026 and $9,844,000 in fiscal year 2027 are from the general fund for funding formula for community health

boards grants for funding formula for foundational public health responsibilities under Minnesota Statutes, section 145A.131, subdivision 1, paragraph (f).

Subd. 30. **Public Health AmeriCorps**

$321,000 in fiscal year 2026 and $321,000 in fiscal year 2027 are from the general fund for Public Health AmeriCorps under Minnesota Statutes, section 144.0759.

Subd. 31. **Cannabis and Substance Misuse Prevention and Education Programs; Local and Tribal Health Departments**

$3,756,000 in fiscal year 2026 and $3,756,000 in fiscal year 2027 are from the general fund for the cannabis and substance misuse prevention and education program for local and Tribal health departments under Minnesota Statutes, section 144.197, subdivision 4.

Subd. 32. **Cannabis and Substance Misuse Prevention and Education Programs; Local and Tribal Health Departments**

$1,500,000 in fiscal year 2026 and $1,500,000 in fiscal year 2027 are from the general fund for the cannabis and substance misuse prevention and education program for local and Tribal health departments under Minnesota Statutes, section 144.197, subdivision 4.

Subd. 33. **Local and Tribal Public Health Emergency Preparedness and Response Grant Program**

$8,400,000 in fiscal year 2026 and $8,400,000 in fiscal year 2027 are from the general fund for the local and Tribal public health emergency preparedness and response grant

program under Minnesota Statutes, section 145A.135.

Subd. 34. **Special Grants**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for special grants under Minnesota Statutes, section 145A.14.

Subd. 35. **Special Grants; Tribal Governments**

$1,166,000 in fiscal year 2026 and $1,166,000 in fiscal year 2027 are from the general fund for special grants to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a.

Subd. 36. **Eliminating Health Disparities**

$3,142,000 in fiscal year 2026 and $3,142,000 in fiscal year 2027 are from the general fund for eliminating health disparities under Minnesota Statutes, section 145.928.

Subd. 37. **Community Solutions for Healthy Child Development Grant Program**

$2,415,000 in fiscal year 2026 and $2,415,000 in fiscal year 2027 are from the general fund for the community solutions for healthy child development grant program under Minnesota Statutes, section 145.9285.

Subd. 38. **African American Health Special Emphasis Grant Program**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund for the African American health special emphasis grant program under Minnesota Statutes, section 144.0756.

Subd. 39. **Office of American Indian Health**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund for the Office of American Indian Health under Minnesota Statutes, section 144.0757.

Subd. 40. **Indian Health Grants; Grants to Tribes**

$535,000 in fiscal year 2026 and $535,000 in fiscal year 2027 are from the general fund for Indian health grants to Tribes under Minnesota Statutes, section 145A.14, subdivision 2b.

Subd. 41. **Rural Hospital Capital Improvement Grant Program**

$1,755,000 in fiscal year 2026 and $1,755,000 in fiscal year 2027 are from the general fund for the rural hospital capital improvement grant program under Minnesota Statutes, section 144.148.

Subd. 42. **Special Grants; Indian Health Grants**

$174,000 in fiscal year 2026 and $174,000 in fiscal year 2027 are from the general fund for special grants for Indian health grants under Minnesota Statutes, section 145A.14, subdivision 2.

Subd. 43. **Community Clinic Grants**

$311,000 in fiscal year 2026 and $311,000 in fiscal year 2027 are from the general fund for community clinic grants under Minnesota Statutes, section 145.9268.

Subd. 44. **Comprehensive Advanced Life Support**

$508,000 in fiscal year 2026 and $508,000 in fiscal year 2027 are from the general fund for

comprehensive advanced life support under Minnesota Statutes, section 144.6062.

Subd. 45. **Health Care Grants for the Uninsured; Dental Providers**

$50,000 in fiscal year 2026 and $50,000 in fiscal year 2027 are from the general fund for health care grants for the uninsured to dental providers under Minnesota Statutes, section 145.929, subdivision 1.

Subd. 46. **Health Care Grants for the Uninsured; Community Mental Health Programs**

$175,000 in fiscal year 2026 and $175,000 in fiscal year 2027 are from the general fund for the health care grants for the uninsured to community mental health programs, under Minnesota Statutes, section 145.929, subdivision 2.

Subd. 47. **Health Care Grants for the Uninsured; Emergency Medical Assistance Outlier Grant Program**

$590,000 in fiscal year 2026 and $590,000 in fiscal year 2027 are from the general fund for the health care grants for the uninsured to the emergency medical assistance outlier grant program under Minnesota Statutes, section 145.929, subdivision 3.

Subd. 48. **Federally Qualified Health Centers**

$2,425,000 in fiscal year 2026 and $2,425,000 in fiscal year 2027 are from the general fund for federally qualified health centers under Minnesota Statutes, section 145.9269.

Subd. 49. **Medical Education; Distribution of Funds**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the general fund

for funding medical education and research costs under Minnesota Statutes, section 62J.692, subdivision 4.

Subd. 50. **Health Professional Education Loan Forgiveness Program**

$1,600,000 in fiscal year 2026 and $1,600,000 in fiscal year 2027 are from the general fund for the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501.

Subd. 51. **Health Professionals Clinical Training Expansion and Rural and Underserved Clinical Rotations Grant Program; Programs**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for the health professionals clinical training expansion and rural and underserved clinical rotations grant program under Minnesota Statutes, section 144.1505, subdivision 2.

Subd. 52. **Health Professionals Clinical Training Expansion and Rural and Underserved Clinical Rotations Grant Program; Program Oversight**

$..... in fiscal year 2026 and $..... in fiscal year 2027 are from the general fund for program oversight grants for the health professionals clinical training expansion and rural and underserved clinical rotations grant program under Minnesota Statutes, section 144.1505, subdivision 5.

Subd. 53. **Primary Care Residency Expansion Grant Program; Program Oversight**

$1,500,000 in fiscal year 2026 and $1,500,000 in fiscal year 2027 are from the general fund for program oversight grants for the primary care residency expansion grant program under

Minnesota Statutes, section 144.1506, subdivision 5.

Subd. 54. **Home and Community-Based Services Employee Scholarship and Loan Forgiveness Program**

$1,450,000 in fiscal year 2026 and $1,450,000 in fiscal year 2027 are from the general fund for the home and community-based services employee scholarship and loan forgiveness program under Minnesota Statutes, section 144.1503.

Subd. 55. **Federally Qualified Health Centers Registered Apprenticeship Grant Program**

$690,000 in fiscal year 2026 and $690,000 in fiscal year 2027 are from the general fund for the federally qualified health centers registered apprenticeship grant program under Minnesota Statutes, section 145.9272.

Subd. 56. **Primary Care Residency Expansion Grant Program**

$400,000 in fiscal year 2026 and $400,000 in fiscal year 2027 are from the general fund for the primary care residency expansion grant program under Minnesota Statutes, section 144.1506.

Subd. 57. **Pediatric Primary Care Mental Health Training Grant Program**

$900,000 in fiscal year 2026 and $900,000 in fiscal year 2027 are from the general fund for the pediatric primary care mental health training grant program under Minnesota Statutes, section 144.1509.

Subd. 58. **Mental Health Cultural Community Continuing Education Grant Program**

$450,000 in fiscal year 2026 and $450,000 in fiscal year 2027 are from the general fund for the mental health cultural community continuing education grant program under Minnesota Statutes, section 144.1511.

Subd. 59. **Clinical Dental Education Innovation Grants**

$1,122,000 in fiscal year 2026 and $1,122,000 in fiscal year 2027 are from the general fund for clinical dental education innovation grants under Minnesota Statutes, section 144.1913.

Subd. 60. **Comprehensive Drug Overdose and Morbidity Prevention Act**

$7,520,000 in fiscal year 2026 and $7,520,000 in fiscal year 2027 are from the general fund for the Comprehensive Drug Overdose and Morbidity Prevention Act under Minnesota Statutes, section 144.0528.

Subd. 61. **Minnesota Poison Information Centers; Establishment**

$2,379,000 in fiscal year 2026 and $2,379,000 in fiscal year 2027 are from the general fund for Minnesota poison information centers under Minnesota Statutes, section 145.93.

Subd. 62. **Suicide Prevention**

$1,977,000 in fiscal year 2026 and $1,977,000 in fiscal year 2027 are from the general fund for suicide prevention under Minnesota Statutes, section 145.56.

Subd. 63. **Sage Cancer Screening Grants**

$518,000 in fiscal year 2026 and $518,000 in fiscal year 2027 are from the general fund for Sage Cancer Screening grants.

Subd. 64. **Regional Navigator Grants**

$4,120,000 in fiscal year 2027 are from the general fund for regional navigator grants under Minnesota Statutes, section 145.4717.

Subd. 65. **Substance Use Treatment, Recovery, and Prevention Grants**

$4,950,000 in fiscal year 2026 and $4,950,000 in fiscal year 2027 are from the general fund for substance use treatment, recovery, and prevention grants under Minnesota Statutes, section 342.72.

Subd. 66. **Community Health Workers; Grants Authorized**

$750,000 in fiscal year 2026 and $750,000 in fiscal year 2027 are from the general fund for community health workers grants under Minnesota Statutes, section 144.1462.

Subd. 67. **Long COVID and Related Conditions; Assessment and Monitoring**

$900,000 in fiscal year 2026 and $900,000 in fiscal year 2027 are from the general fund for long COVID and related conditions assessment and monitoring under Minnesota Statutes, section 145.361.

Subd. 68. **Alzheimer's Public Information Program**

$80,000 in fiscal year 2026 and $80,000 in fiscal year 2027 are from the general fund for the Alzheimer's public information program

under Laws 2023, chapter 70, article 20, section 3, subdivision 2, paragraph (v).

Subd. 69. **Labor Trafficking Services Grant Program**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for the labor trafficking services grant program under Minnesota Statutes, section 144.3885.

Subd. 70. **Safe Harbor Regional Navigator**

$300,000 in fiscal year 2026 and $300,000 in fiscal year 2027 are from the general fund for safe harbor regional navigator grants under Laws 2023, chapter 70, article 20, section 3, subdivision 2, paragraph (nn).

Subd. 71. **Cannabis and Substance Misuse Prevention and Education Programs; Youth Prevention and Education Program**

$1,500,000 in fiscal year 2026 and $1,500,000 in fiscal year 2027 are from the general fund for the cannabis and substance misuse youth prevention and education program under Minnesota Statutes, section 144.197, subdivision 1.

Subd. 72. **Minnesota Poison Information Centers; Establishment**

$795,000 in fiscal year 2026 and $795,000 in fiscal year 2027 are from the general fund for the Minnesota poison information centers under Minnesota Statutes, section 145.93.

Subd. 73. **Statewide Health Improvement Program; Grants to Local Communities**

$14,364,000 in fiscal year 2026 and $14,364,000 in fiscal year 2027 are from the health care access fund for the statewide health improvement program grants to local

communities under Minnesota Statutes, section 145.986, subdivision 1a.

Subd. 74. **Primary Care Residency Training Grant Program**

$4,060,000 in fiscal year 2026 and $4,060,000 in fiscal year 2027 are from the health care access fund for the primary care residency training grant program under Minnesota Statutes, section 144.1507.

Subd. 75. **Health Professionals Clinical Training Expansion and Rural and Underserved Clinical Rotations Grant Programs**

$..... in fiscal year 2026 and $..... in fiscal year 2027 are from the health care access fund for the health professionals clinical training expansion and rural and underserved clinical rotations grant programs under Minnesota Statutes, section 144.1505.

Subd. 76. **International Medical Graduates Assistance Program**

$420,000 in fiscal year 2026 and $420,000 in fiscal year 2027 are from the health care access fund for the international medical graduates assistance program under Minnesota Statutes, section 144.1911.

Subd. 77. **Clinical Health Care Training; Site-Based Clinical Training Grants**

$4,657,000 in fiscal year 2026 and $3,451,000 in fiscal year 2027 are from the health care access fund for the clinical health care site-based clinical training grants under Minnesota Statutes, section 144.1508; Laws 2023, chapter 70, article 20, section 3, subdivision 2, paragraph (n), clause (3).

Subd. 78. **Health Professionals Education Loan Forgiveness Program**

$6,740,000 in fiscal year 2026 and $6,740,000 in fiscal year 2027 are from the health care access fund for the health professionals education loan forgiveness program under Minnesota Statutes, section 144.1501.

Subd. 79. **Medical Education**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the health care access fund for medical education under Minnesota Statutes, section 62J.692.

Subd. 80. **Community Clinics Grants**

$250,000 in fiscal year 2026 and $250,000 in fiscal year 2027 are from the health care access fund for community clinic grants under Minnesota Statutes, section 145.9268.

Subd. 81. **Rural Hospital Planning and Transition Grant Program**

$300,000 in fiscal year 2026 and $300,000 in fiscal year 2027 are from the health care access fund for the rural hospital planning and transition grant program under Minnesota Statutes, section 144.147.

Subd. 82. **Greater Minnesota Family Medicine Residency Grant Program**

$1,000,000 in fiscal year 2026 and $1,000,000 in fiscal year 2027 are from the health care access fund for the greater Minnesota family medicine residency grant program under Minnesota Statutes, section 144.1912.

Subd. 83. **Summer Health Care Interns**

$300,000 in fiscal year 2026 and $300,000 in fiscal year 2027 are from the health care

access fund for summer health care interns under Minnesota Statutes, section 144.1464.

Subd. 84. **National Health Service Match; Federal NHSC Match Grants**

$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are from the health care access fund for National Health Service Match; Federal NHSC Match Grants.

Subd. 85. **Federally Qualified Health Centers**

$219,000 in fiscal year 2026 and $219,000 in fiscal year 2027 are from the health care access fund for federally qualified health centers under Minnesota Statutes, section 145.9269.

Subd. 86. **International Medical Graduates Assistance Program**

$867,000 in fiscal year 2026 and $867,000 in fiscal year 2027 are from the health care access fund for the international medical graduates assistance program under Minnesota Statutes, section 144.1911.

Subd. 87. **Health Care Grants for the Uninsured; Dental Providers**

$63,000 in fiscal year 2026 and $63,000 in fiscal year 2027 are from the health care access fund for health care grants for the uninsured to dental providers under Minnesota Statutes, section 145.929, subdivision 1.

Subd. 88. **Health Care Grants for the Uninsured; Community Mental Health Programs**

$219,000 in fiscal year 2026 and $219,000 in fiscal year 2027 are from the health care access fund for the health care grants for the uninsured for community mental health

programs under Minnesota Statutes, section 145.929, subdivision 2.

Subd. 89. **Health Care Grants for the Uninsured; Emergency Medical Assistance Outlier Grant Program**

$725,000 in fiscal year 2026 and $725,000 in fiscal year 2027 are from the health care access fund for the health care grants for the uninsured for the emergency medical assistance outlier grant program under Minnesota Statutes, section 145.929, subdivision 3.

Subd. 90. **Grant for "Treat Yourself First" Campaign**

$237,000 is from the general fund for a grant to the Minnesota Medical Association for the "Treat Yourself First" campaign. The campaign must be an awareness and education campaign focused on burnout and well-being of health care workers designed to:

(1) reduce the stigma of receiving mental health services;

(2) encourage health care workers who are experiencing workplace-related fatigue to receive the care they need; and

(3) normalize the process for seeking help.

The campaign must be targeted to health care professionals, including but not limited to physicians, nurses, dentists, pharmacists, and other members of the health care team. The campaign must include resources for health care professionals seeking help to address burnout and well-being. This is a onetime appropriation and is available until June 30, 2029.

Subd. 91. **Grant for African American-Focused Homeplace Program**

$475,000 in fiscal year 2026 is from the general fund for a grant to the Birth Justice Collaborative to strengthen and implement the current model of the African American-focused Homeplace in Hennepin County. This is a onetime appropriation and is available until June 30, 2029.

Subd. 92. **TANF Appropriations**

TANF funds must be used as follows:

(1) $3,579,000 in fiscal year 2026 and $3,579,000 in fiscal year 2027 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2026 and $4,978,000 in fiscal year 2027 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. Of these amounts, $4,000,000 in fiscal year 2026 and $4,000,000 in fiscal year 2027 must be distributed to community health boards under Minnesota Statutes, section 145A.131, subdivision 1; and $978,000 in fiscal year 2026 and $978,000 in fiscal year

2027 must be distributed to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2026 and $1,156,000 in fiscal year 2027 are from the TANF fund for sexual and reproductive health services grants under Minnesota Statutes, section 145.925; and

(5) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

Subd. 93. **TANF Carryforward**

Any unexpended balance of the TANF appropriation in the first year does not cancel but is available in the second year.

Subd. 94. **Base Level Adjustment**

The general fund base for this section is $213,725,000 in fiscal year 2028 and $213,725,000 in fiscal year 2029.

Sec. 4. **HEALTH PROTECTION**

Subdivision 1. **Total Appropriation**		**$ 121,207,000**	**$ 120,269,000**
Appropriations by Fund			
General		34,228,000	33,758,000
State Government Special Revenue		86,979,000	86,511,000

Subd. 2. **Speech Language Pathology Assistants Fee Adjustment**

$95,000 in fiscal year 2026 is from the general fund for onetime costs incurred in fiscal year 2025 to implement Minnesota Statutes, sections 148.511 to 148.5198.

Subd. 3. **Lead Abatement Program**

$479,000 in fiscal year 2026 and $479,000 in fiscal year 2027 are from the general fund for the lead abatement program under Minnesota Statutes, section 144.9512.

Subd. 4. **Healthy Housing Grants**

$240,000 in fiscal year 2026 and $240,000 in fiscal year 2027 are from the general fund for healthy housing grants under Minnesota Statutes, section 144.9513.

Subd. 5. **Lead Remediation in School and Child Care Settings Grant Program**

$239,000 in fiscal year 2026 and $239,000 in fiscal year 2027 are from the general fund for lead remediation in school and child care settings grant program under Minnesota Statutes, section 145.9275.

Subd. 6. **Refugee Health and TB Grants**

$245,000 in fiscal year 2026 and $245,000 in fiscal year 2027 are from the general fund for refugee health and TB grants.

Subd. 7. **HIV Prevention Grants**

$1,281,000 in fiscal year 2026 and $1,281,000 in fiscal year 2027 are from the general fund for HIV prevention grants under Minnesota Statutes, section 145.924.

Subd. 8. **Tuberculosis Grants**

$115,000 in fiscal year 2026 and $115,000 in fiscal year 2027 are from the general fund for tuberculosis grants.

Subd. 9. **Comprehensive Drug Overdose and Morbidity Prevention Act**

$960,000 in fiscal year 2026 and $960,000 in fiscal year 2027 are from the general fund for the comprehensive drug overdose and morbidity prevention act under Minnesota Statutes, section 144.0528.

Subd. 10. **Infectious Disease Prevention, Early Detection, and Outbreak Response**

$1,300,000 in fiscal year 2026 and $1,300,000 in fiscal year 2027 are from the general fund for infectious disease prevention, early detection, and outbreak response activities under Minnesota Statutes, section 144.05, subdivision 1.

Subd. 11. **Asbestos Abatement**

$176,000 in fiscal year 2026 and $176,000 in fiscal year 2027 are from the state government special revenue fund for asbestos abatement under Minnesota Statutes, section 326.75.

Subd. 12. **Food, Pools, and Lodging Services**

$5,483,000 in fiscal year 2026 and $5,483,000 in fiscal year 2027 are from the state government special revenue fund for food, pools, and lodging services program activities under Minnesota Statutes, chapters 144, 157, and 327.

Subd. 13. **Public Water Supply**

$7,827,000 in fiscal year 2026 and $7,827,000 in fiscal year 2027 are from the state government special revenue fund to administer the drinking water protection program, including implementing the Safe Drinking Water Act and providing services to regulated parties, partners, and the public under Minnesota Statutes, sections 144.381 to 144.383.

Subd. 14. **Radioactive Materials**

$200,000 in fiscal year 2026 and $200,000 in fiscal year 2027 are from the state government special revenue fund for radioactive materials program activities under Minnesota Statutes, section 144.1205.

Subd. 15. **Ionizing Radiation**

$993,000 in fiscal year 2026 and $828,000 in fiscal year 2027 are from the state government special revenue fund to administer new regulatory activities for x-ray service providers, ongoing inspections of licensed facilities, and data analysis for program planning and implementation under Minnesota Statutes, section 144.121.

Subd. 16. **Engineering Plan Reviews**

$224,000 in fiscal year 2026 and $224,000 in fiscal year 2027 are from the state government special revenue fund to conduct engineering plan reviews under Minnesota Statutes, section 144.554.

Subd. 17. **Spoken Language Health Care Interpreter Workgroup**

$186,000 in fiscal year 2026 and $49,000 in fiscal year 2027 are from the state government special revenue fund for a request for proposals for the spoken language health care interpreter work group. This is a onetime appropriation and is available until June 30, 2029.

Subd. 18. **Base Level Adjustments**

The state government special revenue fund base is $86,794,000 in fiscal year 2028 and $86,806,000 in fiscal year 2029.

Sec. 5. **HEALTH OPERATIONS** **$ 21,776,000 $ 24,249,000**

Appropriations by Fund		
General	20,365,000	21,392,000
Health Care Access	1,411,000	2,857,000

Sec. 6. **TRANSFERS.**

Positions, salary money, and nonsalary administrative money may be transferred within the Department of Health as the commissioner deems necessary with the advance approval of the commissioner of management and budget. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance quarterly about transfers made under this section.

Sec. 7. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioner of health shall not use indirect cost allocations to pay for the operational costs of any program for which the commissioner is responsible.

Sec. 8. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 9. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit or an appropriation is made available after June 30, 2027.

ARTICLE 27

OTHER AGENCY APPROPRIATIONS

Section 1. **OTHER AGENCY APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2026	**2027**
Sec. 2. **HEALTH-RELATED BOARDS**		
Subdivision 1. **Total Appropriation**	**$ 34,231,000**	**$ 34,112,000**

Appropriations by Fund

	2026	2027
General	468,000	468,000
State Government Special Revenue	33,763,000	33,644,000

These amounts are appropriated from the state government special revenue fund, unless specified otherwise, for the purposes specified in the following subdivisions.

Subd. 2. **Board of Behavioral Health and Therapy**	1,289,000	1,289,000
Subd. 3. **Board of Chiropractic Examiners**	666,000	666,000

Subd. 4. **Board of Dentistry** 4,308,000 4,310,000

(a) **Administrative services unit; operating costs.** Of this appropriation, $1,936,000 in fiscal year 2026 and $1,936,000 in fiscal year 2027 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative services unit; volunteer health care provider program.** Of this appropriation, $150,000 in fiscal year 2026 and $150,000 in fiscal year 2027 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative services unit; retirement costs.** Of this appropriation, $237,000 in fiscal year 2026 and $237,000 in fiscal year 2027 are for the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. If the amount appropriated in the first year of the biennium is not sufficient, the amount from the second year of the biennium is available.

(d) **Administrative services unit; contested cases and other legal proceedings.** Of this appropriation, $200,000 in fiscal year 2026 and $200,000 in fiscal year 2027 are for costs of contested case hearings and other

unanticipated costs of legal proceedings involving health-related boards under this section. Upon certification by a health-related board to the administrative services unit that unanticipated costs for legal proceedings will be incurred and that available appropriations are insufficient to pay for the unanticipated costs for that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of costs for contested case hearings and other unanticipated costs of legal proceedings with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance or an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 5. **Board of Dietetics and Nutrition Practice**	277,000	277,000
Subd. 6. **Board of Executives for Long-term Services and Supports**	736,000	736,000
Subd. 7. **Board of Marriage and Family Therapy**	457,000	457,000
Subd. 8. **Board of Medical Practice**	6,196,000	6,141,000

Base Level Adjustment. The state government special revenue fund base for this subdivision is $6,121,000 in fiscal year 2028 and $6,121,000 in fiscal year 2029.

Subd. 9. **Board of Nursing**	6,275,000	6,275,000
Subd. 10. **Board of Occupational Therapy Practice**	560,000	560,000
Subd. 11. **Board of Optometry**	280,000	280,000
Subd. 12. **Board of Pharmacy**	6,748,000	6,748,000

	Appropriations by Fund		
General	468,000	468,000	
State Government Special Revenue	6,280,000	6,280,000	
Subd. 13. **Board of Physical Therapy**		789,000	789,000
Subd. 14. **Board of Podiatric Medicine**		257,000	257,000
Subd. 15. **Board of Psychology**		2,781,000	2,781,000
Health Professional Service Program.			
$1,324,000 in fiscal year 2026 and $1,324,000 in fiscal year 2027 are for the health professionals services program.			
Subd. 16. **Board of Social Work**		2,068,000	2,002,000
Subd. 17. **Board of Veterinary Medicine**		544,000	544,000
Sec. 3. **OFFICE OF EMERGENCY MEDICAL SERVICES**		**$ 7,613,000**	**$ 6,048,000**
Subdivision 1. **Ambulance Service Training and Staffing Grant Program**			
$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are for the ambulance service training and staffing grant program under Minnesota Statutes, section 144E.38.			
Subd. 2. **EMR/EMT Education Reimbursement**			
$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are for EMR/EMT education reimbursements under Minnesota Statutes, section 144E.35.			
Sec. 4. **OMBUDSPERSON FOR FAMILIES**		**$ 792,000**	**$ 808,000**
Sec. 5. **OMBUDSPERSON FOR AMERICAN INDIAN FAMILIES**		**$ 344,000**	**$ 347,000**
Sec. 6. **RARE DISEASE ADVISORY COUNCIL**		**$ 674,000**	**$ 679,000**
Sec. 7. **OFFICE OF THE FOSTER YOUTH OMBUDSPERSON**		**$ 1,012,000**	**$ 1,025,000**
Sec. 8. **BOARD OF DIRECTORS OF MNSURE**		**$ 70,000**	**$ 70,000**

Sec. 9. **COMMISSIONER OF EDUCATION** **$ 7,950,000 $ 7,950,000**

Early Childhood Literacy Programs.

$7,950,000 in fiscal year 2026 and $7,950,000 in fiscal year 2027 are for early childhood literacy grants under Minnesota Statutes, section 142D.12, subdivision 3.

Sec. 10. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 11. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires June 30, 2027, unless a different expiration date is explicit or an appropriation is made available after June 30, 2027.

Sec. 12. Laws 2024, chapter 127, article 67, section 4, is amended to read:

Sec. 4. **BOARD OF PHARMACY**

	Appropriations by Fund	
General	1,500,000	-0-
State Government Special Revenue	-0-	27,000

(a) **Legal Costs.** $1,500,000 in fiscal year 2024 is from the general fund for legal costs. This is a onetime appropriation and is available until June 30, 2027.

(b) **Base Level Adjustment.** The state government special revenue fund base is increased by $27,000 in fiscal year 2026 and increased by $27,000 in fiscal year 2027.

EFFECTIVE DATE. This section is effective June 30, 2025.

APPENDIX
Article locations for S2669-1

62E.21 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal act as defined in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following that offer individual health plans and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;

(2) a nonprofit health service plan corporation operating under chapter 62C; or

(3) a health maintenance organization operating under chapter 62D.

Subd. 9. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.

62E.22 DUTIES OF COMMISSIONER.

The commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Minnesota premium security plan had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

62E.23 MINNESOTA PREMIUM SECURITY PLAN.

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members

of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) will improve access to health care providers and services for those in the individual market;

(4) mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) take into account any federal funding available for the plan; and

(6) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8.

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

(c) Notwithstanding paragraph (a), the payment parameters for benefit years 2023 through 2027 are:

(1) an attachment point of $50,000;

(2) a coinsurance rate of 80 percent; and

(3) a reinsurance cap of $250,000.

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health carrier may request reinsurance payments from the association when the eligible health carrier meets the requirements of this subdivision and subdivision 4.

(b) An eligible health carrier must make requests for reinsurance payments in accordance with any requirements established by the board.

(c) An eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) An eligible health carrier must provide the access described in paragraph (c) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(f) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

(g) The association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier must ensure that its contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval;

(2) implement the approved plan; and

(3) provide the association with written documentation of the corrective action once taken.

Subd. 6. **Data.** Government data of the association under this section are private data on individuals, or nonpublic data, as defined under section 13.02, subdivision 9 or 12.

62E.24 ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.

Subdivision 1. **Accounting.** The board must keep an accounting for each benefit year of all:

(1) funds appropriated for reinsurance payments and administrative and operational expenses;

(2) requests for reinsurance payments received from eligible health carriers;

(3) reinsurance payments made to eligible health carriers; and

(4) administrative and operational expenses incurred for the plan.

Subd. 2. **Reports.** (a) The board must submit to the commissioner and to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and make available to the public quarterly reports on plan operations and an annual report summarizing the plan operations for each benefit year. All reports must be made public by posting the report on the Minnesota Comprehensive Health Association website. The annual summary must be made available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

(b) The reports must include information about:

(1) the reinsurance parameters used;

(2) the metal levels affected;

(3) the number of claims payments estimated and submitted for payment per products offered on-exchange and off-exchange and per eligible health carrier;

(4) the estimated reinsurance payments by plan type based on carrier-submitted templates;

(5) funds appropriated for reinsurance payments and administrative and operational expenses for each year, including the federal and state contributions received, investment income, and any other revenue or funds received;

(6) the total amount of reinsurance payments made to each eligible health carrier; and

(7) administrative and operational expenses incurred for the plan, including the total amount incurred and as a percentage of the plan's operational budget.

Subd. 3. **Legislative auditor.** The Minnesota premium security plan is subject to audit by the legislative auditor. The board must ensure that its contractors, subcontractors, or agents cooperate with the audit.

Subd. 4. **Independent external audit.** (a) The board must engage and cooperate with an independent certified public accountant or CPA firm licensed or permitted under chapter 326A to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner the results of the audit;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 5; and

(3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association website and making the audit results otherwise available.

Subd. 5. **Actions on audit findings.** (a) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the corrective action plan; and

(3) provide the commissioner with written documentation of the corrective actions taken.

(b) By December 1 of each year, the board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance regarding any finding of material weakness or significant deficiency found in an audit.

62E.25 ACCOUNTS.

Subdivision 1. **Premium security plan account.** The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational and administrative costs and reinsurance payments relating to the start-up and operation of the Minnesota premium security plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account shall be credited to the premium security plan account.

Subd. 2. **Deposits.** Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

Subd. 3. **Basic health plan trust account.** Funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8, that are attributable to the basic health program shall be deposited in the basic health plan trust account in the federal fund.

62J.824 FACILITY FEE DISCLOSURE.

(a) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient, including patients served by telehealth as defined in section 62A.673, subdivision 2, paragraph (h), stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(b) Each health care facility must post prominently in locations easily accessible to and visible by patients, including on its website, a statement that the provider-based clinic is part of a hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(c) This section does not apply to laboratory services, imaging services, or other ancillary health services that are provided by staff who are not employed by the health care facility or clinic.

(d) For purposes of this section:

(1) "facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and

(2) "provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

62K.10 GEOGRAPHIC ACCESSIBILITY; PROVIDER NETWORK ADEQUACY.

Subd. 3. **Other health services.** The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

103I.550 LIMITED PUMP, PITLESS, OR DUG WELL/DRIVE POINT CONTRACTOR.

Subdivision 1. **Limited pump or pitless license or certification.** A person with a limited well/boring contractor's license or certification to install well pumps and pumping equipment; or a person with a limited well/boring contractor's license or certification to install, repair, and modify pitless units and pitless adapters, well casings above the pitless unit or pitless adapter, and well screens and well diameters, will be issued a combined license or certification to: (1) install well pumps and pumping equipment; and (2) install, repair, and modify pitless units and pitless adapters, well casings above the pitless unit or pitless adapter, well screens, and well diameters.

Subd. 2. **Limited dug well/drive point license or certification.** A person with a limited well/boring contractor's license or certification to construct, repair, and seal drive point wells and dug wells will be issued a well contractor's license or certification.

136A.29 POWERS; DUTIES.

Subd. 4. **Mutual agreement; staff, equipment, office space.** By mutual agreement between the authority and the office, authority staff employees may also be members of the office staff. By mutual agreement, authority employees may be provided office space in the office of the Office of Higher Education, and said employees may make use of equipment, supplies, and office space, provided that the authority fully reimburses the office for salaries and for space, equipment, supplies, and materials used. In the absence of such mutual agreement between the authority and the office, the authority may maintain an office at such place or places as it may designate.

138.912 HEALTHY EATING, HERE AT HOME.

Subd. 7. **Grocery inclusion.** The commissioner of children, youth, and families must submit a waiver request to the federal United States Department of Agriculture seeking approval for the inclusion of Minnesota grocery stores in this program so that SNAP participants may use the vouchers for healthy produce at grocery stores. Grocery store participation is voluntary and a grocery store's associated administrative costs will not be reimbursed.

142A.15 PUBLIC ASSISTANCE LIEN ON RECIPIENT'S CAUSE OF ACTION.

Subdivision 1. **State agency has lien.** When the state agency provides, pays for, or becomes liable for medical care or furnishes subsistence or other payments to a person, the agency shall have a lien for the cost of the care and payments on any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury that accrue to the person to whom the care or payments were furnished, or to the person's legal representatives, as a result of the occurrence that necessitated the medical care, subsistence, or other payments. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256L.01, subdivision 7, 256L.03, subdivision 6, and 256L.12, and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes reimbursed under chapter 256R; and county-based purchasing entities under section 256B.692.

Subd. 2. **Perfection; enforcement.** (a) The state agency may perfect and enforce its lien under sections 514.69, 514.70, and 514.71, and must file the verified lien statement with the appropriate court administrator in the county of financial responsibility. The verified lien statement must contain the following: the name and address of the person to whom medical care, subsistence, or other payment was furnished; the date of injury; the name and address of vendors furnishing medical care; the dates of the service or payment; the amount claimed to be due for the care or payment; and to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries.

(b) This section does not affect the priority of any attorney's lien. The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is first received by it under subdivision 4, paragraph (c), even if the notice is untimely, or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received, or (2) the date the person's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later.

(c) If the notice required in subdivision 4 is not provided by any of the parties to the claim at any stage of the claim, the state agency will have one year from the date the state agency learns of the lack of notice to commence an action. If amounts on the claim or cause of action are paid and the amount required to be paid to the state agency under subdivision 5 is not paid to the state agency, the state agency may commence an action to recover on the lien against any or all of the parties or entities that have either paid or received the payments.

Subd. 3. **Prosecutor.** (a) The attorney general shall represent the commissioner to enforce the lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on behalf of the commissioner against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(b) Any prepaid health plan providing services under sections 256B.69 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes reimbursed under chapter 256R; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce their lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

Subd. 4. **Notice.** (a) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages to the injured person when the state agency has paid for or become liable for the cost of medical care or payments related to the injury. Notice must be given as provided in this subdivision.

(b) Applicants for public assistance shall notify the state or county agency of any possible claims they may have against a person, firm, or corporation when they submit the application for assistance. Recipients of public assistance shall notify the state or county agency of any possible claims when those claims arise.

(c) A person providing medical care services to a recipient of public assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(d) A party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim at each of the following stages of a claim:

(1) when a claim is filed;

(2) when an action is commenced; and

(3) when a claim is concluded by payment, award, judgment, settlement, or otherwise.

(e) Every party involved in any stage of a claim under this subdivision is required to provide notice to the state agency at that stage of the claim. However, when one of the parties to the claim provides notice at that stage, every other party to the claim is deemed to have provided the required notice at that stage of the claim. If the required notice under this paragraph is not provided to the state agency, every party will be deemed to have failed to provide the required notice. A party to a claim includes the injured person or the person's legal representative, the plaintiff, the defendants, or persons alleged to be responsible for compensating the injured person or plaintiff, and any other party to the cause of action or claim, regardless of whether the party knows the state agency has a potential or actual lien claim.

(f) Notice given to the county agency is not sufficient to meet the requirements of paragraphs (c) and (d).

Subd. 5. **Costs deducted.** Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has filed its lien, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of public assistance paid to or on behalf of the person as a result of the injury must be deducted next, and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and other collection costs.

Subd. 6. **When effective.** The lien created under this section is effective with respect to any public assistance paid on or after August 1, 1987.

Subd. 7. **Cooperation with information requests required.** (a) Upon the request of the commissioner:

(1) any state agency or third-party payer shall cooperate by furnishing information to help establish a third-party liability, as required by the federal Deficit Reduction Act of 2005, Public Law 109-171;

(2) any employer or third-party payer shall cooperate by furnishing a data file containing information about group health insurance plan or medical benefit plan coverage of its employees or insureds within 60 days of the request. The information in the data file must include at least the following: full name, date of birth, Social Security number if collected and stored in a system routinely used for producing data files by the employer or third-party payer, employer name, policy identification number, group identification number, and plan or coverage type.

(b) For purposes of section 176.191, subdivision 4, the commissioner of labor and industry may allow the commissioner of children, youth, and families and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the commissioner of human services.

(c) For the purpose of compliance with section 169.09, subdivision 13, and federal requirements under Code of Federal Regulations, title 42, section 433.138(d)(4), the commissioner of public safety shall provide accident data as requested by the commissioner of children, youth, and families. The disclosure shall not violate section 169.09, subdivision 13, paragraph (d).

(d) The commissioner of children, youth, and families and county agencies shall limit its use of information gained from agencies, third-party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third-party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

142E.50 DEFINITIONS.

Subd. 2. **Applicant.** "Applicant" has the meaning given in section 142E.01, subdivision 2.

Subd. 12. **Provider.** "Provider" means either a provider as defined in section 142E.01, subdivision 22, or a legal unlicensed provider as defined in section 142E.01, subdivision 19.

148.108 FEES.

Subd. 2. **Annual renewal of inactive acupuncture registration.** The annual renewal of an inactive acupuncture registration fee is $25.

Subd. 3. **Acupuncture reinstatement.** The acupuncture reinstatement fee is $50.

Subd. 4. **Animal chiropractic.** (a) Animal chiropractic registration fee is $125.

(b) Animal chiropractic registration renewal fee is $75.

(c) Animal chiropractic inactive renewal fee is $25.

148.6402 DEFINITIONS.

Subd. 22a. **Limited license.** "Limited license" means a license issued according to section 148.6425, subdivision 3, paragraph (c), to persons who for two years or more did not apply for a license after meeting the requirements in section 148.6408 or 148.6410 or who allowed their license to lapse for four years or more.

148.6420 APPLICATION REQUIREMENTS.

Subd. 2. **Persons applying for licensure under section 148.6408 or 148.6410.** Persons applying for licensure under section 148.6408 or 148.6410 must submit the materials required in subdivision 1 and the following:

(1) a certificate of successful completion of the requirements in section 148.6408, subdivision 1, or 148.6410, subdivision 1; and

(2) the applicant's test results from the examining agency, as evidence that the applicant received a qualifying score on a credentialing examination meeting the requirements of section 148.6408, subdivision 2, or 148.6410, subdivision 2.

Subd. 3. **Applicants certified by National Board for Certification in Occupational Therapy.** An applicant who is certified by the National Board for Certification in Occupational Therapy must provide the materials required in subdivision 1 and the following:

(1) verified documentation from the National Board for Certification in Occupational Therapy stating that the applicant is certified as an occupational therapist, registered or certified occupational therapy assistant, the date certification was granted, and the applicant's certification number. The document must also include a statement regarding disciplinary actions. The applicant is responsible for obtaining this documentation by sending a form provided by the board to the National Board for Certification in Occupational Therapy; and

(2) a waiver authorizing the board to obtain access to the applicant's records maintained by the National Board for Certification in Occupational Therapy.

Subd. 4. **Applicants credentialed in another jurisdiction.** In addition to providing the materials required in subdivision 1, an applicant credentialed in another jurisdiction must request that the appropriate government body in each jurisdiction in which the applicant holds or held an occupational therapy credential provide documentation to the board that verifies the applicant's credentials. Except as provided in section 148.6418, a license must not be issued until the board receives verification of each of the applicant's credentials. Each verification must include the applicant's name and date of birth, credential number and date of issuance, a statement regarding investigations pending and disciplinary actions taken or pending against the applicant, current status of the credential, and the terms under which the credential was issued.

148.6423 LICENSURE RENEWAL.

Subd. 4. **License renewal cycle conversion.** The license renewal cycle for occupational therapy licensees is converted to a two-year cycle where renewal is due on the last day of the licensee's month of birth. Conversion pursuant to this section begins January 1, 2021. This section governs license renewal procedures for licensees who were licensed before December 31, 2020. The conversion renewal cycle is the renewal cycle following the first license renewal after January 1, 2020. The conversion license period is the license period for the conversion renewal cycle. The conversion license period is between 13 and 24 months and ends on the last day of the licensee's month of birth in either 2022 or 2023, as described in subdivision 5.

Subd. 5. **Conversion of license renewal cycle for current licensees.** For a licensee whose license is current as of December 31, 2020, the licensee's conversion license period begins on January 1, 2021, and ends on the last day of the licensee's month of birth in 2023, except that for licensees whose month of birth is January, February, March, April, May, or June, the licensee's renewal cycle ends on the last day of the licensee's month of birth in 2022.

Subd. 7. **Subsequent renewal cycles.** After the licensee's conversion renewal cycle under subdivision 5 or 6, subsequent renewal cycles are biennial and begin on the first day of the month following the licensee's birth month.

Subd. 8. **Conversion period and fees.** (a) A licensee who holds a license issued before January 1, 2021, and who renews that license pursuant to subdivision 5 or 6, must pay a renewal fee as required in this subdivision.

(b) A licensee must be charged the biennial license fee listed in section 148.6445 for the conversion license period.

(c) For a licensee whose conversion license period is 13 to 24 months, the first biennial license fee charged after the conversion license period must be adjusted to credit the excess fee payment made during the conversion license period. The credit is calculated by:

(1) subtracting the number of months of the licensee's conversion license period from 24; and

(2) multiplying the result of clause (1) by 1/24 of the biennial fee rounded up to the next dollar.

(d) For a licensee whose conversion license period is 24 months, the first biennial license fee charged after the conversion license period must not be adjusted.

(e) For the second and all subsequent license renewals made after the conversion license period, the licensee's biennial license fee is as listed in section 148.6445.

Subd. 9. **Expiration.** Subdivisions 4, 5, 7, and 8 expire December 31, 2023.

148.6425 RENEWAL OF LICENSURE; AFTER EXPIRATION DATE.

Subd. 3. **Licensure renewal four years or more after licensure expiration date.** (a) An individual who requests licensure renewal four years or more after the licensure expiration date must submit the following:

(1) a completed and signed application for licensure on forms provided by the board;

(2) the renewal fee and the late fee required under section 148.6445 if renewal application is based on paragraph (b), clause (1), (2), or (3), or the renewal fee required under section 148.6445 if renewal application is based on paragraph (b), clause (4);

(3) proof of having met the continuing education requirement in section 148.6443, subdivision 1, except the continuing education must be obtained in the two years immediately preceding application renewal; and

(4) at the time of the next licensure renewal, proof of having met the continuing education requirement, which shall be prorated based on the number of months licensed during the two-year licensure period.

(b) In addition to the requirements in paragraph (a), the applicant must submit proof of one of the following:

(1) verified documentation of successful completion of 160 hours of supervised practice approved by the board as described in paragraph (c);

(2) verified documentation of having achieved a qualifying score on the credentialing examination for occupational therapists or the credentialing examination for occupational therapy assistants administered within the past year;

(3) documentation of having completed a combination of occupational therapy courses or an occupational therapy refresher program that contains both a theoretical and clinical component approved by the board. Only courses completed within one year preceding the date of the application or one year after the date of the application qualify for approval; or

(4) evidence that the applicant holds a current and unrestricted credential for the practice of occupational therapy in another jurisdiction and that the applicant's credential from that jurisdiction has been held in good standing during the period of lapse.

(c) To participate in a supervised practice as described in paragraph (b), clause (1), the applicant shall obtain limited licensure. To apply for limited licensure, the applicant shall submit the completed limited licensure application, fees, and agreement for supervision of an occupational therapist or occupational therapy assistant practicing under limited licensure signed by the supervising therapist and the applicant. The supervising occupational therapist shall state the proposed level of supervision on the supervision agreement form provided by the board. The supervising therapist shall determine the frequency and manner of supervision based on the condition of the patient or client, the complexity of the procedure, and the proficiencies of the supervised occupational therapist. At a minimum, a supervising occupational therapist shall be on the premises at all times that the person practicing under limited licensure is working; be in the room ten percent of the hours worked each week by the person practicing under limited licensure; and provide daily face-to-face collaboration for the purpose of observing service competency of the occupational therapist or occupational therapy assistant, discussing treatment procedures and each client's response to treatment, and reviewing and modifying, as necessary, each treatment plan. The supervising therapist shall document the supervision provided. The occupational therapist participating in a supervised practice is responsible for obtaining the supervision required under this paragraph and must comply with the board's requirements for supervision during the entire 160 hours of supervised practice. The supervised practice must be completed in two months and may be completed at the applicant's place of work.

(d) In addition to the requirements in paragraphs (a) and (b), the applicant must submit additional information as requested by the board to clarify information in the application, including information to determine whether the applicant has engaged in conduct warranting disciplinary action as set forth in section 148.6448. The information must be submitted within 30 days after the board's request.

148.6430 DELEGATION OF DUTIES; ASSIGNMENT OF TASKS.

The occupational therapist is responsible for all duties delegated to the occupational therapy assistant or tasks assigned to direct service personnel. The occupational therapist may delegate to an occupational therapy assistant those portions of a client's evaluation, reevaluation, and intervention that, according to prevailing national practice standards, can be performed by an occupational therapy assistant. The occupational therapist may not delegate portions of an evaluation or reevaluation of a person whose condition is changing rapidly.

148.6445 FEES.

Subd. 5. **Limited licensure fee.** The fee for limited licensure is $100.

Subd. 6. **Fee for course approval after lapse of licensure.** The fee for course approval after lapse of licensure is $100.

Subd. 8. **Verification to institutions.** The fee for verification of licensure to institutions is $10.

156.015 FEES.

Subdivision 1. **Verification of licensure.** The board may charge a fee of $25 per license verification to a licensee for verification of licensure status provided to other veterinary licensing boards.

245A.02 DEFINITIONS.

Subd. 6d. **Foster family setting.** "Foster family setting" has the meaning given in Minnesota Rules, part 2960.3010, subpart 23, and includes settings licensed by the commissioner of human services or the commissioner of corrections.

245A.11 SPECIAL CONDITIONS FOR RESIDENTIAL PROGRAMS.

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, 2012, as a component of the quality outcome standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

(b) Providers licensed under chapter 245B, and providing, contracting, or arranging for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105 to 9555.6265; and meeting the provisions of section 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

256B.0622 ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES.

Subd. 4. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

256B.0625 COVERED SERVICES.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.

256G.02 DEFINITIONS.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 5. **Department.** "Department" means the Department of Human Services.

261.003 ELIGIBILITY STANDARDS, RULES.

The commissioner of human services shall promulgate rules in accordance with chapter 14, prescribing minimum standards of eligibility and payment for poor relief, which shall recognize cost of living differences in the various counties of the state.

2500.1150 FEES.

The fees charged by the board are fixed at the following rates:

A. peer review fee to be paid by a requesting doctor or by a requesting insurance company, $100;

B. licensing examination regrade fee, $30;

C. copy of a board order or stipulation fee, $10 each;

D. certificate of good standing or licensure verification to other states, $10 each;

E. duplicate of the original license or of an annual renewal, $10;

F. miscellaneous copying fee, 25 cents per page;

G. independent medical examination registration fee, $150;

H. independent examination annual renewal fee, $100;

I. incorporation renewal late charge, $5 per month;

J. computer lists, $100; and

K. computer printed labels, $150.

2500.2030 ANNUAL RENEWAL OF INACTIVE LICENSE.

The annual renewal fee for an inactive license is 75 percent of the current fee imposed by the board for license renewal.

4695.2900 APPLICATION FEES.

Fees to be submitted with initial or renewal applications shall be as follows:

A. Initial application fee, $45 plus examination fees.

B. Biennial renewal application fee, $45.

C. Penalty for late submission of renewal application, $10, if not renewed by designated renewal date.

6800.5100 DEFINITIONS.

Subp. 5. **Pharmacist-intern; intern.** "Pharmacist-intern" and "intern" mean:

A. a natural person satisfactorily progressing toward the degree in pharmacy required for licensure;

B. a graduate of the University of Minnesota College of Pharmacy, or other pharmacy college approved by the board, who is registered by the Board of Pharmacy for the purpose of obtaining practical experience as a requirement for licensure as a pharmacist;

C. a qualified applicant awaiting examination for licensure; or

D. a participant in a residency or fellowship program, not licensed to practice pharmacy in the state of Minnesota, who is a licensed pharmacist in another state or who is a graduate of the University of Minnesota College of Pharmacy or another pharmacy college approved by the board.

6800.5400 TRAINING.

Subp. 5. **Competencies.** Upon registration, interns and preceptors will be furnished a copy of the board's internship manual, which lists the minimum competencies that should be the focus of internship training. The competencies are furnished to suggest appropriate types and order of training experience and shall be used to ensure that the intern's practical experiences are commensurate with the intern's educational level, and broad in scope.

Subp. 6. **Evidence of completion.** Applicants for licensure as pharmacists who are examined and licensed after September 17, 1973, shall submit evidence that they have successfully completed not less than 1,500 hours of internship under the instruction and supervision of a preceptor. Effective May 1, 2003, candidates for licensure shall submit evidence that they have successfully completed not less than 1,600 hours of internship under the direction and supervision of a preceptor. Credit for internship shall be granted only to registered interns who have completed the third year of the five-year or six-year pharmacy curriculum, provided, however, that:

A. no more than 400 hours of concurrent time internship will be granted to an intern; and

B. 800 hours of internship credit may be acquired through experiential education program experiences that do not have as their focus traditional compounding, dispensing, and related patient counseling activities. The remaining 800 hours of the 1,600 hour total requirement must focus on traditional compounding, dispensing, and related patient counseling activities.

6900.0250 FEES.

Subpart 1. **Amounts.** The amount of fees may be set by the board with the approval of the Department of Management and Budget up to the limits provided in this subpart depending upon the total amount required to sustain board operations under Minnesota Statutes, section 16A.1285, subdivision 2. Information about fees in effect at any time is available from the board office. The maximum amount of fees are:

A. application for licensure, $600;

B. renewal license, $600;

C. late renewal fee, $100;

D. temporary permit, $250;

E. duplicate license or duplicate renewal certificate, $10;

F. reinstatement, $650;

G. exam administration to persons who have not applied for a license or permit, $50;

H. fee for verification of licensure, $30; and

I. miscellaneous fee:

(1) labels, $25;

(2) list of licensees, $25; and

(3) copies, 25 cents per page.

Subp. 2. **Requirements.** Fees must be paid in United States money and are not refundable.

9100.0400 APPLICATION AND EXAMINATION FEES FOR LICENSURE TO PRACTICE VETERINARY MEDICINE.

Subpart 1. **Application fee.**

A. A person applying for a license to practice veterinary medicine in Minnesota or applying for a permit to take the national veterinary medical examination must pay a $50 nonrefundable application fee to the board. Persons submitting concurrent applications for licensure and a national examination permit shall pay only one application fee.

B. The application fee received supports only the application with which the fee was submitted. A person who applies more than once must submit the full application fee with each subsequent application.

Subp. 3. **Examination fees.**

A. All applicants for veterinary licensure in Minnesota must successfully pass the Minnesota Veterinary Jurisprudence Examination. The fee for this examination is $50, payable to the board.

B. An applicant participating in the national veterinary licensing examination must complete a separate application for the national examination and submit the application to the board for approval. Payment for the national examination must be made by the applicant to the national board examination committee after the application for examination has been approved by the board.

9100.0500 INITIAL AND RENEWAL FEE.

Subpart 1. **Required for licensure.** Each person now licensed to practice veterinary medicine in this state, or who becomes licensed by the Board of Veterinary Medicine to engage in the practice, shall pay an initial fee or a biennial license renewal fee if the person wishes to practice veterinary medicine in the coming two-year period or remain licensed as a veterinarian. A licensure period begins on March 1 and expires the last day of February two years later. A licensee with an even-numbered license shall renew by March 1 of even-numbered years and a licensee with an odd-numbered license shall renew by March 1 of odd-numbered years. For 1996 license renewals, licensees with an even-numbered license shall renew for two years. Licensees with an odd-numbered license shall renew for one year and commence renewal for a two-year period in 1997.

Subp. 2. **Amount.** The initial licensure fee and the biennial renewal fee is $200 and must be paid to the executive director of the board on or before March 1 of the first year of the biennial license period. By January 1 of the first year for which the biennial renewal fee is due, the board shall issue a renewal application to each current licensee to the last address maintained in the board file. Failure to receive this notice does not relieve the licensee of the obligation to pay renewal fees so that they are received by the board on or before the renewal date of March 1.

Initial licenses issued after the start of the licensure renewal period are valid only until the end of the period.

Subp. 3. **Date due.** A licensee must apply for a renewal license on or before March 1 of the first year of the biennial license renewal period. A renewal license is valid from March 1 through the last day of February of the last year of the two-year license renewal period. An application postmarked no later than the last day of February must be considered to have been received on March 1.

Subp. 4. **Late renewal penalty.** An applicant for renewal must pay a late renewal penalty of $100 in addition to the renewal fee if the application for renewal is received after March 1 of the licensure renewal period. A renewed license issued after March 1 of the licensure renewal period is valid only to the end of the period regardless of when the renewal fee is received.

Subp. 4a. **Reinstatement fee.** An applicant for license renewal whose license has previously been suspended by official board action for nonrenewal must pay a reinstatement fee of $50 in addition to the $200 renewal fee and the $100 late renewal penalty.

Subp. 5. **Penalty for failure to pay.** Within 30 days after the renewal date, a licensee who has not renewed the license must be notified by letter sent to the last known address of the licensee in the file of the board that the renewal is overdue and that failure to pay the current fee and current late fee within 60 days after the renewal date will result in suspension of the license. A second notice must be sent by registered or certified mail at least seven

days before a board meeting occurring 60 days or more after the renewal date to each licensee who has not paid the renewal fee and late fee.

Subp. 6. **Suspension.** The board, by means of a roll call vote, shall suspend the license of a licensee whose license renewal is at least 60 days overdue and to whom notification has been sent as provided in subpart 5. Failure of a licensee to receive notification is not grounds for later challenge by the licensee of the suspension. The former licensee must be notified by registered or certified letter within seven days of the board action. The suspended status placed on a license may be removed only on payment of renewal fees and late penalty fees for each licensure period or part of a period that the license was not renewed. A licensee who fails to renew a license for five years or more must meet the criteria of Minnesota Statutes, section 156.071, for relicensure.

Subp. 7. **Inactive license.** A person holding a current unrestricted license to practice veterinary medicine in Minnesota may, at the time of the person's next biennial license renewal date, renew the license as an inactive license at one-half the renewal fee of an unrestricted license. The license may be continued in an inactive status by renewal on a biennial basis at one-half the regular license fee.

A. A person holding an inactive license is not permitted to practice veterinary medicine in Minnesota and remains under the disciplinary authority of the board.

B. A person may convert a current inactive license to an unrestricted license upon application to and approval by the board. The application must include:

(1) documentation of licensure in good standing and of having met continuing education requirements of current state of practice, or documentation of having met Minnesota continuing education requirements retroactive to the date of licensure inactivation;

(2) certification by the applicant that the applicant is not currently under disciplinary orders or investigation for acts that could result in disciplinary action in any other jurisdiction; and

(3) payment of a fee equal to the full difference between an inactive and unrestricted license if converting during the first year of the biennial license cycle or payment of a fee equal to one-half the difference between an inactive and an unrestricted license if converting during the second year of the license cycle.

C. Deadline for renewal of an inactive license is March 1 of the first year of the biennial license renewal period. A late renewal penalty of one-half the inactive renewal fee must be paid if renewal is received after March 1.

9100.0600 MISCELLANEOUS FEES.

Subpart 1. **Temporary license fee.** A person meeting the requirements for issuance of a temporary permit to practice veterinary medicine under Minnesota Statutes, section 156.072, subdivision 5, pending examination, who desires a temporary permit shall pay a fee of $50 to the board.

Subp. 2. **Duplicate license.** A person requesting issuance of a duplicate or replacement license shall pay a fee of $10 to the board.