SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 3295

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
04/07/2025	1708	Introduction and first reading
		Referred to Health and Human Services
04/07/2026	7296a	Comm report: To pass as amended
	7904	Second reading
04/22/2026	8977a	Special Order: Amended
	8989	Third reading Passed as amended
		See SF4476

A bill for an act

relating to state government; modifying provisions relating to health-related occupations, the Department of Health, human services health care, behavioral health, the Department of Human Services Office of the Inspector General, the medication repository program, drugs, the health care provider wellness program, direct primary care services, emergency medical services, and children, youth, and families; requiring a report; amending Minnesota Statutes 2024, sections 62A.01, by adding a subdivision; 62A.011, subdivision 3; 62D.02, subdivision 7, by adding a subdivision; 62D.08, subdivisions 5, 6; 62D.09, subdivisions 1, 5; 62D.124, subdivision 6; 62J.17, subdivision 6a; 62J.2930, subdivision 1; 62J.497, subdivision 5; 62J.536, subdivision 2a; 62K.02, subdivision 2; 62K.03, subdivision 6; 62K.075; 62K.105; 62K.14; 62M.07, subdivision 2; 62Q.46, subdivision 1; 62V.05, subdivision 7; 62V.13; 142A.43; 142B.10, subdivision 18; 142G.18, subdivision 1; 144.059, subdivision 8; 144.293, subdivision 7; 144.551, subdivision 1; 144E.123, subdivision 1, by adding a subdivision; 145.56, subdivision 5; 145.561, subdivision 2; 145.882, by adding subdivisions; 145A.04, subdivision 15; 148.01, subdivisions 1, 4, by adding subdivisions; 148.09; 148.10, by adding a subdivision; 148.102, subdivision 3; 148.105, subdivision 1; 148.517, subdivisions 1, 2; 148.5191, subdivision 4; 151.01, subdivision 35, by adding a subdivision; 151.065, subdivisions 4a, 4b, by adding subdivisions; 151.14; 151.19, subdivision 1; 151.555, subdivision 7; 214.41; 245.991, subdivision 3; 245.992, subdivisions 1, 2; 245C.04, subdivision 1; 245D.04, subdivision 3, by adding a subdivision; 245D.10, subdivision 4; 245I.04, by adding a subdivision; 245I.08, subdivision 4; 256B.055, subdivision 17; 256B.057, subdivision 9; 256B.0624, subdivisions 6b, 7; 256B.0625, subdivisions 4, 47; 256B.0943, subdivision 6; 256B.0946, subdivision 4; 256B.0947, subdivision 5; 256D.05, subdivision 1; 256D.06, subdivision 2; 256D.54, subdivision 1; 256I.04, subdivision 2b; 256L.05, subdivision 3; 256L.06, subdivision 3; 259.83, subdivision 1; 260.67, subdivision 1; 260C.190, subdivision 1; 260C.212, subdivision 4a; 260C.451, subdivisions 2, 3, 3a; 260E.02, subdivisions 1, 2, by adding a subdivision; Minnesota Statutes 2025 Supplement, sections 3.732, subdivision 1; 62J.84, subdivisions 2, 3, 10, 11, 12, 13, 14; 62K.10, subdivision 2; 148.108, subdivision 5; 245.469, subdivision 1; 245.4889, subdivision 1; 245A.10, subdivision 4; 245A.142, subdivision 3; 245A.242, subdivision 2; 245I.04, subdivision 17; 245I.23, subdivision 7; 254B.04, subdivision 1a; 256B.0625, subdivision 5m; 256B.0943, subdivisions 1, 9; 256B.0947, subdivision 3a; 256B.695, subdivision 5; 256L.03, subdivision 5; 260C.451, subdivision 8; 260E.03, subdivision 6; 260E.11, subdivision 1; 260E.14, subdivision 1; 626.5572, subdivision 13; Laws 2024, chapter 125, article 4, section 12, subdivision 5; Laws

2025, First Special Session chapter 3, article 22, section 20, subdivision 2; article 23, section 2, subdivision 12; proposing coding for new law in Minnesota Statutes, chapters 62Q; 148; 151; 245; repealing Minnesota Statutes 2024, sections 13D.08, subdivision 4; 62D.08, subdivision 7; 62D.181; 62J.06; 62J.156; 62J.2930, subdivision 4; 62J.57; 62U.10, subdivision 4; 144.9821; 151.13; 256B.69, subdivision 31a; 256D.024, subdivision 1; 256D.09, subdivisions 2a, 2b; Minnesota Rules, parts 2500.0100, subparts 5b, 6, 12; 2500.1900; 2500.2020; 2500.2040; 2500.2100; 2500.2110; 6800.0400; 6800.1150.

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

ARTICLE 1

HEALTH-RELATED OCCUPATIONS

Section 1. Minnesota Statutes 2024, section 148.01, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For the purposes of sections 148.01 to 148.10:

(1) "abnormal articulation" means the condition of opposing bony joint surfaces and their related soft tissues that do not function normally, including subluxation, fixation, adhesion, degeneration, deformity, dislocation, or other pathology that results in pain or disturbances within the nervous system, results in postural alteration, inhibits motion, allows excessive motion, alters direction of motion, or results in loss of axial loading efficiency, or a combination of these;

(2) "acupuncture" means a modality of treating abnormal physical conditions by stimulating various points of the body or interruption of the cutaneous integrity by needle insertion to secure a reflex relief of the symptoms by nerve stimulation as utilized as an adjunct to chiropractic adjustment;

(3) "animal chiropractic diagnosis and treatment" means treatment that includes identification and resolution of vertebral subluxation complexes, spinal manipulation, and manipulation of the extremity articulations of nonhuman vertebrates. Animal chiropractic diagnosis and treatment does not include:

(i) performing surgery;

(ii) dispensing or administering medications; or

(iii) performing traditional veterinary care and diagnosis;

~~(1)~~ (4) "chiropractic" means the health care discipline that recognizes the innate recuperative power of the body to heal itself without the use of drugs or surgery by identifying and caring for vertebral subluxations and other abnormal articulations by emphasizing the relationship between structure and function as coordinated by the nervous system and how that relationship affects the preservation and restoration of health;

~~(2)~~ (5) "chiropractic services" means the evaluation and facilitation of structural, biomechanical, and neurological function and integrity through the use of adjustment, manipulation, mobilization, or other procedures accomplished by manual or mechanical forces applied to bones or joints and their related soft tissues for correction of vertebral subluxation, other abnormal articulations, neurological disturbances, structural alterations, or biomechanical alterations, and includes~~,~~ but is not limited to~~,~~ manual therapy and mechanical therapy as defined in section 146.23;

~~(3) "abnormal articulation" means the condition of opposing bony joint surfaces and their related soft tissues that do not function normally, including subluxation, fixation, adhesion, degeneration, deformity, dislocation, or other pathology that results in pain or disturbances within the nervous system, results in postural alteration, inhibits motion, allows excessive motion, alters direction of motion, or results in loss of axial loading efficiency, or a combination of these;~~

~~(4)~~ (6) "diagnosis" means the physical, clinical, and laboratory examination of the patient, and the use of diagnostic services for diagnostic purposes within the scope of the practice of chiropractic described in sections 148.01 to 148.10;

~~(5)~~ (7) "diagnostic services" means clinical, physical, laboratory, and other diagnostic measures, including diagnostic imaging that may be necessary to determine the presence or absence of a condition, deficiency, deformity, abnormality, or disease as a basis for evaluation of a health concern, diagnosis, differential diagnosis, treatment, further examination, or referral;

(8) "good standing" means that a license is not the subject of current disciplinary action under section 148.10 or an equivalent disciplinary law in another jurisdiction;

(9) "reinstatement" means the process by which a board-terminated license or voluntarily retired license returns to active license status under section 148.071 or 148.076;

~~(6)~~ (10) "therapeutic services" means rehabilitative therapy as defined in Minnesota Rules, part 2500.0100, subpart 11, and all of the therapeutic, rehabilitative, and preventive sciences and procedures for which the licensee was subject to examination under section 148.06~~. When provided, therapeutic services must be performed within a practice where the primary focus is the provision of chiropractic services, to prepare the patient for chiropractic services, or to complement the provision of chiropractic services. The administration of therapeutic services is the responsibility of the treating chiropractor and must be rendered under the direct supervision of qualified staff~~; and

~~(7) "acupuncture" means a modality of treating abnormal physical conditions by stimulating various points of the body or interruption of the cutaneous integrity by needle insertion to secure a reflex relief of the symptoms by nerve stimulation as utilized as an adjunct to chiropractic adjustment. Acupuncture may not be used as an independent therapy or separately from chiropractic services. Acupuncture is permitted under section 148.01 only after registration with the board which requires completion of a board-approved course of study and successful completion of a board-approved national examination on acupuncture. Renewal of registration shall require completion of board-approved continuing education requirements in acupuncture. The restrictions of section 147B.02, subdivision 2, apply to individuals registered to perform acupuncture under this section; and~~

~~(8) "animal chiropractic diagnosis and treatment" means treatment that includes identifying and resolving vertebral subluxation complexes, spinal manipulation, and manipulation of the extremity articulations of nonhuman vertebrates. Animal chiropractic diagnosis and treatment does not include:~~

~~(i) performing surgery;~~

~~(ii) dispensing or administering of medications; or~~

~~(iii) performing traditional veterinary care and diagnosis.~~

(11) "voluntarily retired license" means a license held by a chiropractor who has changed the chiropractor's license status to a voluntarily retired license under section 148.075.

Sec. 2. Minnesota Statutes 2024, section 148.01, subdivision 4, is amended to read:

Subd. 4. **Practice of chiropractic.** An individual licensed to practice under section 148.06 is authorized to perform chiropractic services~~, acupuncture,~~ and therapeutic services, and to provide diagnosis and to render opinions pertaining to those services for the purpose of determining a course of action in the best interests of the patient, such as a treatment plan, appropriate referral, or both.

Sec. 3. Minnesota Statutes 2024, section 148.01, is amended by adding a subdivision to read:

Subd. 5. **Practice of therapeutic services.** Therapeutic services must be performed within a practice where the primary focus is the provision of chiropractic services, preparing the patient for chiropractic services, or complementing the provision of chiropractic services. The administration of therapeutic services is the responsibility of the treating chiropractor and must be rendered under the direct supervision of qualified staff.

Sec. 4. Minnesota Statutes 2024, section 148.01, is amended by adding a subdivision to read:

Subd. 6. **Practice of acupuncture.** Acupuncture must not be used as an independent therapy or separately from chiropractic services. Acupuncture is permitted under this section only after registration with the board, which requires completing a board-approved course of study and a board-approved national examination on acupuncture. Renewal of registration requires completing board-approved continuing education requirements in acupuncture. The restrictions of section 147B.02, subdivision 2, apply to individuals registered to perform acupuncture under this section.

Sec. 5. **[148.071] REINSTATEMENT OF A LICENSE TERMINATED FOR FAILING TO RENEW OR TO COMPLETE CONTINUING EDUCATION.**

Subdivision 1. **Scope.** This section applies to a chiropractor whose Minnesota license was terminated by the board for failing to timely renew the license or complete annual continuing education requirements.

Subd. 2. **Application requirements.** At the time of application for reinstatement, the applicant must:

(1) submit an application for reinstatement and pay the application fee;

(2) pay the current renewal fee;

(3) complete a criminal background check as prescribed under section 214.075 and pay the required fee;

(4) submit license verification from each jurisdiction where the applicant holds or has held a chiropractic license;

(5) submit evidence of passing the board's jurisprudence exam;

(6) submit evidence of correcting any outstanding requirements and paying any outstanding fees that existed at the time the license was terminated; and

(7) complete any additional applicable requirements established in subdivisions 3, 4, 5, 6, and 9.

Subd. 3. **Reinstatement of terminated license for licensee in good standing in another jurisdiction.** The board must reinstate the license of an applicant who is currently licensed and in good standing in another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2;

(2) provides verification of the active chiropractic license in good standing in another jurisdiction; and

(3) provides verification of completing 20 continuing education hours in the year immediately preceding the application for reinstatement.

Subd. 4. **Reinstatement of terminated license after five years or less.** The board must reinstate the license of an applicant who does not meet the requirements of subdivision 3 and who applies for reinstatement five years or less after license termination in Minnesota or another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2; and

(2) provides verification of:

(i) completing 20 continuing education hours for each year since the applicant last held an active license in good standing in Minnesota or another jurisdiction and 20 continuing education hours in the year immediately preceding the application for reinstatement; or

(ii) passing the Special Purposes Examination for Chiropractic, or an alternate examination the board determines is equivalent, within 12 months after application.

Subd. 5. **Reinstatement of terminated license after more than five years.** The board must reinstate the license of an applicant who does not meet the requirements of subdivision 3 and who applies for reinstatement more than five years after license termination in Minnesota or another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2;

(2) provides verification of completing 20 continuing education hours for each year since the applicant last held an active license in good standing in Minnesota or another jurisdiction and 20 continuing education hours in the year immediately preceding the application for reinstatement, not to exceed a maximum of 100 required continuing education hours; and

(3) provides verification of passing the Special Purposes Examination for Chiropractic, or an alternate examination the board determines is equivalent, within 12 months after application.

Subd. 6. **Reinstatement within the same calendar year of continuing education termination.** The board must reinstate the license of an applicant whose license was terminated for failing to submit the required number of continuing education hours if within the same calendar year of termination the applicant:

(1) completes the required number of continuing education hours and outstanding penalty hours imposed by the board; and

(2) pays all application fees and penalty fees.

Subd. 7. **Board authority.** Applications for reinstatement and licenses reinstated under this section are subject to the same board authority under sections 148.10 and 214.103 as other applications and licenses issued by the board to deny, refuse to issue, revoke, suspend, condition, or limit a license or to take disciplinary or corrective action against a licensee or applicant for conduct that violates applicable law or professional standards.

Subd. 8. **Continuing education in year of reinstatement.** A licensee must not use continuing education hours obtained for the purpose of applying for reinstatement of a terminated license under this section to meet the annual hour requirement for the year in which the license is reinstated.

Subd. 9. **Previously terminated licenses.** If a chiropractor's license was terminated before July 1, 2026, and the chiropractor applies for reinstatement under this section, the chiropractor is not required to repay any renewal fees that accrued before the license reinstatement.

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

Sec. 6. **[148.075] VOLUNTARILY RETIRED LICENSE.**

Subdivision 1. **Application.** A Minnesota licensed chiropractor in good standing and with no continuing education audit deficiencies may apply to the board to voluntarily retire a license by submitting an application on a form provided by the board and a signed affidavit stating that the applicant will no longer actively practice chiropractic in Minnesota.

Subd. 2. **Grounds for denial.** The board may deny an application to voluntarily retire a license if the applicant's Minnesota license or license issued in another jurisdiction is not in good standing or is subject to a pending disciplinary action.

Sec. 7. **[148.076] REINSTATEMENT OF A VOLUNTARILY RETIRED LICENSE.**

Subdivision 1. **Scope.** This section applies to a chiropractor who voluntarily retired a Minnesota chiropractic license under section 148.075.

Subd. 2. **Application requirements.** At the time of application for reinstatement, the applicant must:

(1) submit an application for reinstatement;

(2) pay the current renewal fee;

(3) complete a criminal background check as prescribed under section 214.075 and pay the required fee;

(4) submit license verification from each jurisdiction where the applicant holds or has held a chiropractic license;

(5) submit evidence of passing the board's jurisprudence exam;

(6) submit evidence of correcting any outstanding requirements and paying any outstanding fees that existed at the time the license was voluntarily retired; and

(7) complete any additional applicable requirements in subdivisions 3, 4, 5, and 7.

Subd. 3. **Reinstatement of voluntarily retired license for licensee in good standing in another jurisdiction.** The board must reinstate the license of an applicant who is currently licensed and in good standing in another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2;

(2) provides verification of the active chiropractic license in good standing in another jurisdiction; and

(3) provides verification of completing 20 continuing education hours in the year immediately preceding the application for reinstatement.

Subd. 4. **Reinstatement of voluntarily retired license after five years or less.** The board must reinstate the license of an applicant who does not meet the requirements of subdivision 3 and who applies for reinstatement five years or less after voluntary license retirement in Minnesota or the equivalent in another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2; and

(2) provides verification of:

(i) completing 20 continuing education hours for each year since the applicant last held an active license in good standing in Minnesota or another jurisdiction and 20 continuing education hours in the year immediately preceding the application for reinstatement; or

(ii) passing the Special Purposes Examination for Chiropractic, or an alternate examination the board determines is equivalent, within 12 months after application.

Subd. 5. **Reinstatement of voluntarily retired license after more than five years.** The board must reinstate the license of an applicant who does not meet the requirements of

subdivision 3 and who applies for reinstatement more than five years after voluntary license retirement in Minnesota or the equivalent in another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2;

(2) provides verification of completing 20 continuing education hours for each year since the applicant last held an active license in good standing in Minnesota or another jurisdiction and 20 continuing education hours in the year immediately preceding the application for reinstatement, not to exceed a maximum of 100 required continuing education hours; and

(3) provides verification of passing the Special Purposes Examination for Chiropractic, or an alternate examination the board determines is equivalent, within 12 months after application.

Subd. 6. **Board authority.** Applications for reinstatement and licenses reinstated under this section are subject to the same board authority under sections 148.10 and 214.103 as other applications and licenses issued by the board to deny, refuse to issue, revoke, suspend, condition, or limit a license or to take disciplinary or corrective action against a licensee or applicant for conduct that violates applicable law or professional standards.

Subd. 7. **Continuing education in year of reinstatement.** A licensee must not use continuing education hours obtained for the purpose of applying for reinstatement of a voluntarily retired license under this section to meet the annual hour requirement for the year the license is reinstated.

Subd. 8. **Previously voluntarily retired licensees.** (a) If a chiropractor who voluntarily retired before July 1, 2026, applies for reinstatement under this section, the chiropractor is not required to repay any renewal fees that accrued before the license reinstatement.

(b) Before reinstatement under this subdivision, the voluntarily retired licensee must complete any outstanding continuing education hours due at the time the license was voluntarily retired.

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

Sec. 8. Minnesota Statutes 2024, section 148.09, is amended to read:

148.09 INDEPENDENT EXAMINATION.

Subdivision 1. **Requirements for examiners.** (a) A doctor of chiropractic conducting a physical examination of a patient or a review of records by a doctor of chiropractic, for the purpose of generating a report or opinion to aid a reparation obligor under chapter 65B

in making a determination regarding the condition or further treatment of the patient, shall meet the following requirements:

(1) the doctor of chiropractic must either be an instructor at an accredited school of chiropractic or have devoted not less than 50 percent of practice time to direct patient care during the two years immediately preceding the examination;

(2) the doctor of chiropractic must have completed any annual continuing education requirements for chiropractors prescribed by the Board of Chiropractic Examiners;

(3) the doctor of chiropractic must not accept a fee of more than $500 for each independent exam conducted; and

(4) the doctor of chiropractic must register with the Board of Chiropractic Examiners as an independent examiner and adhere to all rules governing the practice of chiropractic.

(b) The examiner must identify in the written report the source of all records reviewed and the dates or period of services covered by those records. The examiner's notes and a copy of the final written report must be retained for at least four years following the examination.

(c) Before conducting an independent examination, the examiner must provide written disclosures to the examinee that clearly state the purpose of the examination and the examinee's right to have a third party present under subdivision 2.

Subd. 2. **Third-party presence during examinations.** (a) An examiner performing an independent examination under this section must not prohibit the examinee from having a third party of the examinee's choice present during the consultation and examination. The examiner must not bar the presence of a third party based on the third party's training or credentials. Advance notice to the examiner or to any other person, organization, or agency is not required for the presence of a third party under this subdivision.

(b) The third party must provide their name to the examiner. The examiner must document the presence and stated identity of any third party in the written report of the examination.

(c) A third party may make a written or audio recording of the consultation or examination if the recording does not obstruct the conduct of the examination. A third party must not make a video recording of the consultation or examination.

(d) An examiner must not consider the examinee's exercise of rights under this subdivision as failing to cooperate with the examination. If an examiner determines that the examination has been obstructed, the examiner must describe in detail the nature of the obstruction in the body of the written report. For purposes of this subdivision, "obstruct" means to hinder

the examination to the degree that the examination cannot be completed, unless the obstruction is necessary for the safety or well-being of the patient.

Subd. 3. **Violation.** A violation of this section constitutes unprofessional conduct under section 148.10, subdivision 1, paragraph (e).

Sec. 9. **[148.095] ADMINISTRATIVE HOLD DURING COMPLAINT RESOLUTION PROCESS.**

Subdivision 1. **Administrative hold.** (a) If there is a pending complaint against a licensee and the licensee fails to pay required renewal fees, fails to renew the license, or fails to complete required continuing education hours within the time prescribed by law, the board must place the license on an administrative hold.

(b) A license on an administrative hold:

(1) is expired and does not authorize the licensee to engage in the practice of chiropractic; and

(2) remains under the board's full jurisdiction for all purposes under sections 148.10 and 214.103, including investigation, adjudication, and imposition of discipline.

Subd. 2. **Prohibition on status change while on administrative hold.** (a) If the board places a license on administrative hold, the board must not:

(1) accept an application to voluntarily retire the license under section 148.075;

(2) terminate the license for failing to renew or to complete continuing education requirements; or

(3) otherwise change the license status of the licensee in a manner that allows the licensee to delay, avoid, or terminate the complaint resolution process.

(b) The board must remove the administrative hold upon the resolution of all pending complaints against the licensee.

Subd. 3. **Licensee obligations not suspended.** An administrative hold on a license does not relieve a licensee of the legal obligation to timely renew the license, pay renewal or other required fees, or complete continuing education hours according to law.

Sec. 10. Minnesota Statutes 2024, section 148.10, is amended by adding a subdivision to read:

Subd. 8. **Loss and restoration of good standing.** The pendency of a complaint does not cause a license to lose good standing unless: (1) the complaint results in disciplinary action under this section or an equivalent disciplinary law in another jurisdiction; or (2) a stipulation and order or an equivalent order in another jurisdiction provides for the loss of good standing. A license is restored to good standing upon the satisfactory completion, expiration, or other agreed-upon termination of all terms of a stipulation and order or an equivalent order in another jurisdiction. An agreement for corrective action as described under section 214.103, subdivision 6, does not cause a license to lose good standing.

Sec. 11. Minnesota Statutes 2024, section 148.102, subdivision 3, is amended to read:

Subd. 3. **Insurers.** ~~Two times each year~~ (a) Every January 1 and July 1, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to chiropractors shall submit to the board a report concerning the chiropractors against whom malpractice settlements or awards have been made to the plaintiff. The report must contain at least the following information:

(1) the total number of malpractice settlements or awards made to the plaintiff;

(2) the date the malpractice settlements or awards to the plaintiff were made;

(3) the allegations contained in the claim or complaint leading to the settlements or awards made to the plaintiff;

(4) the dollar amount of each malpractice settlement or award;

(5) the regular address of the practice of the doctor of chiropractic against whom an award was made or with whom a settlement was made; and

(6) the name of the doctor of chiropractic against whom an award was made or with whom a settlement was made.

(b) The insurance company shall, in addition to the above information, report to the board any information it possesses which tends to substantiate a charge that a doctor of chiropractic may have engaged in conduct violating section 148.10 and this section.

Sec. 12. Minnesota Statutes 2024, section 148.105, subdivision 1, is amended to read:

Subdivision 1. **Generally.** Any person who practices, or attempts to practice, chiropractic or who uses any of the terms or letters "Doctors of Chiropractic," "Chiropractor," "DC," or

any other title or letters under any circumstances as to lead the public to believe that the person who so uses the terms is engaged in the practice of chiropractic, without having complied with the provisions of sections 148.01 to 148.104, is guilty of a gross misdemeanor; and, upon conviction, fined not less than $1,000 nor more than $10,000 or be imprisoned in the county jail for not less than 30 days nor more than six months or punished by both fine and imprisonment, in the discretion of the court. It is the duty of the county attorney of the county in which the person practices to prosecute. Nothing in sections 148.01 to ~~148.105~~ 148.108 shall be considered as interfering with any person:

(1) licensed by a health-related licensing board, as defined in section 214.01, subdivision 2, including psychological practitioners with respect to the use of hypnosis;

(2) registered or licensed by the commissioner of health under section 214.13; or

(3) engaged in other methods of healing regulated by law in the state of Minnesota;

provided that the person confines activities within the scope of the license or other regulation and does not practice or attempt to practice chiropractic.

Sec. 13. Minnesota Statutes 2025 Supplement, section 148.108, subdivision 5, is amended to read:

Subd. 5. **Chiropractic license fees.** Fees for chiropractic licensure are the following amounts but may be adjusted lower by board action:

(1) initial application for licensure ~~fee~~, $300;

(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)~~ (3) late renewal penalty ~~fee~~, $150 per month late; ~~and~~

~~(5)~~ (4) application for reinstatement of a ~~voluntarily retired or inactive~~ terminated license ~~fee~~, ~~$187.50.~~ $100; and

(5) penalty for failure to complete CE requirements at the time of license renewal:

(i) at the first failure to complete CE requirements at the time of license renewal, the amount of the fee for annual renewal of an active license under clause (2);

(ii) at the second failure to complete CE requirements at the time of license renewal, two times the amount of the fee for annual renewal of an active license under clause (2); and

(iii) at the third failure to complete CE requirements at the time of license renewal and every subsequent failure, three times the amount of the fee for annual renewal of an active license under clause (2).

Sec. 14. **[151.064] APPLICATION EXPIRATION.**

Unless otherwise exempted by this chapter or the rules of the board, an application for initial license or registration, renewal, or reinstatement expires if an applicant, licensee, or registrant fails to complete the application within 12 months of the date the board received the application.

Sec. 15. Minnesota Statutes 2024, section 151.065, subdivision 4a, is amended to read:

Subd. 4a. **Application and fee; relocation.** A person who is registered with or licensed by the board must submit a new application to the board before relocating the physical location of the person's business. An application must be submitted for each affected license. The application must set forth the proposed change of location on a form established by the board. If the licensee or registrant remitted payment for the full amount during the state's fiscal year, the relocation application fee is the same as the application fee in subdivision 1, except that the fees in subdivision 1, clauses (6) to (9) and (11) to ~~(16)~~ (15), are reduced by $5,000 and the fee in subdivision 1, clause (16), is reduced by $55,000. If the application is made within ~~60~~ 90 days before the date of the original license or registration expiration, the applicant must pay the full application fee provided in subdivision 1. Upon approval of an application for a relocation, the board shall issue a new license or registration.

Sec. 16. Minnesota Statutes 2024, section 151.065, subdivision 4b, is amended to read:

Subd. 4b. **Application and fee; change of ownership.** (a) A person who is registered with or licensed by the board must submit a new application to the board before changing the ownership of the licensee or registrant. An application must be submitted for each affected license. The application must set forth the proposed change of ownership on a form established by the board. If the licensee or registrant remitted payment for the full amount during the state's fiscal year, the application fee is the same as the application fee in subdivision 1, except that the fees in subdivision 1, clauses (6) to (9) and (11) to ~~(16)~~ (15), are reduced by $5,000 and the fee in subdivision 1, clause (16), is reduced by $55,000. If the application is made within ~~60~~ 90 days before the date of the original license or registration expiration, the applicant must pay the full application fee provided in subdivision 1. Upon approval of an application for a change of ownership, the board shall issue a new license or registration.

(b) The following constitute a change in ownership:

(1) the sale of all or substantially all of the assets of the licensee or registrant;

(2) the addition or removal of one or more partners in a partnership to which a license has been issued;

(3) the transfer of 20 percent or more of the issued voting stock of the licensee or registrant since the original issuance of the license or registration;

(4) the transfer of 20 percent or more ownership interest in the licensee or registrant since the original issuance of the license or registration;

(5) a change in business structure of an owner who possesses 20 percent or more of the issued voting stock of the licensee or registrant; and

(6) a change in business structure of an owner who possesses 20 percent or more ownership interest in the licensee or registrant.

(c) Paragraph (b), clauses (3) and (4), do not apply if the issued voting stock of the licensee or registrant is actively traded on any securities exchange or any over-the-counter market.

(d) "Change in business structure" means a change in the structure of a business between a sole proprietorship, partnership, limited liability company, or corporation.

Sec. 17. Minnesota Statutes 2024, section 151.065, is amended by adding a subdivision to read:

Subd. 4c. **Application and fee; change in business structure.** (a) A person who is registered with or licensed by the board must submit a new application to the board before changing the business structure of the licensee or registrant. A person must submit an application for each affected license. The application must set forth the proposed change of business structure on a form established by the board. If the licensee or registrant remitted payment for the full amount during the state's fiscal year, the application fee is the same as the application fee in subdivision 1, except that the fees in subdivision 1, clauses (6) to (9) and (11) to (15), are reduced by $5,000 and the fee in subdivision 1, clause (16), is reduced by $55,000. If the person submits the application within 90 days before the date of the original license or registration expiration, the applicant must pay the full application fee provided in subdivision 1. Upon approval of an application for a change in business structure, the board shall issue a new license or registration.

(b) "Changing the business structure" means a change in the structure of a business between a sole proprietorship, partnership, limited liability company, or corporation.

Sec. 18. Minnesota Statutes 2024, section 151.065, is amended by adding a subdivision to read:

Subd. 4d. **Temporary use of license or registration.** Unless otherwise exempted by this chapter or the rules of the board, if the physical location of a person's business, the ownership of the licensee or registrant, or the business structure of the licensee or registrant changes under subdivision 4a, 4b, or 4c, the original license or registration expires when the board issues a new license or registration or 30 days after the effective date of the change, whichever is earlier. An expired license or registration is void. A licensee or registrant must surrender an expired license or registration to the board.

Sec. 19. **[151.099] POSTING REQUIREMENT.**

A licensee or registrant must post the license or registration most recently issued by the board in a conspicuous place within or adjacent to the licensed or registered facility at which the licensee or registrant is employed.

Sec. 20. **[151.125] LICENSE AND REGISTRATION EXPIRATION AND RENEWAL.**

Subdivision 1. **License expiration and renewal.** (a) A pharmacist license expires on the last day of February each year. A pharmacist must renew the license annually by filing an application for license renewal and submitting the fee established in section 151.065 on or before February 1 each year. A pharmacist license renewal application received after February 1 is subject to the late filing fee in section 151.065.

(b) A pharmacy license expires June 30 each year. A pharmacy must renew the license annually by filing an application for license renewal and submitting the fee established in section 151.065 on or before June 1 each year. A pharmacy license renewal application received after June 1 is subject to the late filing fee in section 151.065.

(c) A manufacturer license expires May 31 each year. A manufacturer must renew the license annually by filing an application for license renewal and submitting the fee established in section 151.065 on or before May 1 each year. A manufacturer license renewal application received after May 1 is subject to the late filing fee in section 151.065.

(d) A wholesale distributor license expires May 31 each year. A wholesale distributor must renew the license annually by filing an application for license renewal and submitting

the fee established in section 151.065 on or before May 1 each year. A wholesale distributor license renewal application received after May 1 is subject to the late filing fee in section 151.065.

(e) A third-party logistics provider license expires October 31 each year. A third-party logistics provider must renew the license annually by filing an application for license renewal and submitting the fee established in section 151.065 on or before October 1 each year. A third-party logistics provider license renewal application received after October 1 is subject to the late filing fee in section 151.065.

Subd. 2. **Registration and permit expiration and renewal.** (a) A pharmacy technician registration expires December 31 each year. A pharmacy technician must renew the registration annually by filing an application for registration renewal and submitting the fee established in section 151.065 on or before December 1 each year. A technician registration renewal application received after December 1 is subject to the late filing fee in section 151.065.

(b) A controlled substance researcher permit expires May 31 each year. A controlled substance researcher must renew the permit annually by filing an application for permit renewal and submitting the fee established in section 151.065 on or before May 1 each year. A controlled substance researcher renewal application received after May 1 is subject to the late filing fee in section 151.065.

(c) A medical gas dispenser registration expires November 30 each year. A medical gas dispenser must renew the registration annually by filing an application for registration renewal and submitting the fee established in section 151.065 on or before November 1 each year. A medical gas dispenser registration renewal application received after November 1 is subject to the late filing fee in section 151.065.

Subd. 3. **Time limit for renewal.** (a) Unless otherwise exempted in this chapter or by the rules of the board, a pharmacist or pharmacy technician must not pursue renewal under this section if a license or registration has been expired for more than 24 months and must instead pursue reinstatement under section 151.14. A pharmacist may apply for renewal within 24 months of expiration without examination.

(b) Unless otherwise exempted by this chapter or by the rules of the board, a licensee or registrant not subject to paragraph (a) must not pursue renewal under this section if a license or registration has been expired for more than 12 months and must instead pursue reinstatement under section 151.14.

Subd. 4. **Prohibition on practice.** A licensee or registrant whose license or registration has expired must not practice using that license or registration until the license or registration is either renewed under this section or reinstated under section 151.14.

Sec. 21. Minnesota Statutes 2024, section 151.14, is amended to read:

151.14 REINSTATEMENTS.

(a) Any ~~person~~ pharmacist or pharmacy technician who has been licensed or registered by the board and has defaulted in the payment of the renewal fee may ~~be reinstated within two years~~ apply for reinstatement after 24 months of such default ~~without examination,~~ upon payment of ~~the~~ any fees and late fees in arrears and upon compliance with the ~~provisions of section 151.13, subdivision 2~~ continuing education requirements under this chapter and the rules of the board.

(b) Unless otherwise exempted in this chapter or by the rules of the board, a licensee or registrant not subject to paragraph (a) may apply for reinstatement of an expired license or registration after 12 months from the expiration by paying all late and renewal fees and all arrears in section 151.065.

Sec. 22. **[151.145] EXTENSION AND PRORATION OF INITIAL, LATE RENEWAL, AND REINSTATEMENT APPLICATIONS.**

If the board receives an initial, late renewal, or reinstatement application within 90 days before the applicable license or registration type expires under section 151.125, subdivision 1 or 2, the board may extend the license or registration date for that applicant to the subsequent calendar year and prorate the application fee accordingly.

Sec. 23. Minnesota Statutes 2024, section 151.19, subdivision 1, is amended to read:

Subdivision 1. **Pharmacy licensure requirements.** (a) No person shall operate a pharmacy without first obtaining a license from the board and paying any applicable fee specified in section 151.065. The license shall be displayed in a conspicuous place in the pharmacy for which it is issued and expires on June 30 following the date of issue. It is unlawful for any person to operate a pharmacy unless ~~the~~ a license has been issued to the person by the board.

(b) Application for a pharmacy license under this section shall be made in a manner specified by the board.

(c) No license shall be issued or renewed for a pharmacy located within the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and state law and according to rules adopted by the board. No license shall be issued or renewed for a pharmacy located outside of the state unless the applicant agrees to operate the pharmacy in a manner prescribed by federal law and, when dispensing medications for residents of this state, the laws of this state, and Minnesota Rules.

(d) No license shall be issued or renewed for a pharmacy that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of such licensure or registration.

(e) The board shall require a separate license for each pharmacy located within the state and for each pharmacy located outside of the state at which any portion of the dispensing process occurs for drugs dispensed to residents of this state.

(f) Prior to the issuance of an initial or renewed license for a pharmacy, the board may require the pharmacy to pass an inspection conducted by an authorized representative of the board. In the case of a pharmacy located outside of the state, ~~the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless~~ the applicant ~~furnishes~~ must furnish the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may ~~deny licensure~~ refuse to issue or renew any license or may deny a category of license under Minnesota Rules, part 6800.0350, unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) The board shall not issue an initial or renewed license for a pharmacy located outside of the state unless the applicant discloses and certifies:

(1) the location, names, and titles of all principal corporate officers and all pharmacists who are involved in dispensing drugs to residents of this state;

(2) that it maintains its records of drugs dispensed to residents of this state so that the records are readily retrievable from the records of other drugs dispensed;

(3) that it agrees to cooperate with, and provide information to, the board concerning matters related to dispensing drugs to residents of this state;

(4) that, during its regular hours of operation, but no less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate

communication between patients in this state and a pharmacist at the pharmacy who has access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(5) that, upon request of a resident of a long-term care facility located in this state, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with section 151.415, subdivision 5.

(h) This subdivision does not apply to a manufacturer licensed under section 151.252, subdivision 1, a wholesale drug distributor licensed under section 151.47, or a third-party logistics provider, to the extent the manufacturer, wholesale drug distributor, or third-party logistics provider is engaged in the distribution of dialysate or devices necessary to perform home peritoneal dialysis on patients with end-stage renal disease, if:

(1) the manufacturer or its agent leases or owns the licensed manufacturing or wholesaling facility from which the dialysate or devices will be delivered;

(2) the dialysate is comprised of dextrose or icodextrin and has been approved by the United States Food and Drug Administration;

(3) the dialysate is stored and delivered in its original, sealed, and unopened manufacturer's packaging;

(4) the dialysate or devices are delivered only upon:

(i) receipt of a physician's order by a Minnesota licensed pharmacy; and

(ii) the review and processing of the prescription by a pharmacist licensed by the state in which the pharmacy is located, who is employed by or under contract to the pharmacy;

(5) prescriptions, policies, procedures, and records of delivery are maintained by the manufacturer for a minimum of three years and are made available to the board upon request; and

(6) the manufacturer or the manufacturer's agent delivers the dialysate or devices directly to:

(i) a patient with end-stage renal disease for whom the prescription was written or the patient's designee, for the patient's self-administration of the dialysis therapy; or

(ii) a health care provider or institution, for administration or delivery of the dialysis therapy to a patient with end-stage renal disease for whom the prescription was written.

Sec. 24. Minnesota Statutes 2024, section 214.41, is amended to read:

214.41 ~~PHYSICIAN~~ HEALTH CARE PROVIDER WELLNESS PROGRAM.

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

(b) "Health care provider" or "provider" means an individual 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.

(c) "~~physician~~ Health care provider wellness program" means a program for health care providers of evaluation, counseling, or other modality to address an issue related to career fatigue or wellness related to work stress ~~for physicians licensed under chapter 147~~ that is administered by a statewide association that is exempt from taxation under United States Code, title 26, section 501(c)(6), and that primarily represents physicians and osteopaths of multiple specialties. ~~Physician~~ Health care provider wellness program does not include the provision of services intended to monitor for impairment under the authority of section 214.31.

Subd. 2. **Confidentiality.** Any record of a ~~person's~~ health care provider's participation in a ~~physician~~ health care provider wellness program is confidential and not subject to discovery, subpoena, or a reporting requirement to the applicable health-related licensing board or to the commissioner of health, unless the ~~person~~ provider voluntarily provides for written release of the information or the disclosure is required to meet the ~~licensee's~~ provider's obligation to report certain information to the applicable health-related licensing board or the commissioner of health according to ~~section 147.111~~ law governing the practice of the provider's profession.

Subd. 3. **Civil liability.** Any person, agency, institution, facility, or organization employed by, contracting with, or operating a ~~physician~~ health care provider wellness program is immune from civil liability for any action related to their duties in connection with a ~~physician~~ health care provider wellness program when acting in good faith.

Sec. 25. **TRANSITION OF INACTIVE LICENSES.**

On July 1, 2026, the Board of Chiropractic Examiners must administratively change all chiropractic licenses put on inactive license status under Minnesota Rules, part 2500.2020, before that date to a voluntarily retired license under Minnesota Statutes, section 148.075.

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

Sec. 26. **INTERIM CHIROPRACTIC ACUPUNCTURE REGISTRATION REINSTATEMENT PROCEDURES.**

Subdivision 1. **Scope.** This section applies to a chiropractor whose Minnesota chiropractic acupuncture registration was canceled.

Subd. 2. **Application requirements.** At the time of application for reinstatement of an acupuncture registration, the applicant must:

(1) hold an active Minnesota chiropractic license;

(2) submit an application for reinstatement;

(3) pay the current renewal fee;

(4) submit license verification from each jurisdiction where the applicant holds or has held a chiropractic license; and

(5) complete any additional applicable requirements as established in subdivisions 3, 4, and 5.

Subd. 3. **Reinstatement of canceled registration for registrant in good standing in another jurisdiction.** The Board of Chiropractic Examiners must reinstate the chiropractic acupuncture registration of an applicant in good standing in another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2;

(2) provides verification of a chiropractic acupuncture credential in good standing from each jurisdiction where the applicant is authorized to perform chiropractic acupuncture; and

(3) provides verification of completing two continuing education units in acupuncture or acupuncture-related subjects in the year immediately preceding the application for reinstatement.

Subd. 4. **Reinstatement of canceled registration after five years or less.** The board must reinstate the chiropractic acupuncture registration of an applicant who does not meet the requirements of subdivision 3 and who applies for reinstatement five years or less after the Minnesota registration cancellation if the applicant:

(1) completes all requirements in subdivision 2; and

(2) provides verification of:

(i) completing two continuing education hours in acupuncture or acupuncture-related subjects for each year since the applicant last held an active chiropractic acupuncture registration in Minnesota or credential in another jurisdiction; or

(ii) passing the National Board of Chiropractic Examiners Acupuncture Examination or the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Examination, or an alternate examination the board determines is equivalent, within 12 months after application.

Subd. 5. **Reinstatement of canceled registration license after more than five years.** The board must reinstate the chiropractic acupuncture registration of an applicant who does not meet the requirements of subdivision 3 and who applies for reinstatement more than five years after the Minnesota registration cancellation if the applicant:

(1) completes all requirements in subdivision 2; and

(2) provides verification of passing either the National Board of Chiropractic Examiners Acupuncture Examination or the NCCAOM Examination, or an alternative examination the board determines is equivalent, within 12 months after application.

Subd. 6. **Continuing education in year of reinstatement.** A licensee must not use continuing education units obtained for the purpose of applying for reinstatement of a canceled registration under this section to meet the annual requirement for the year the license is reinstated.

Subd. 7. **Board authority.** Applications for reinstatement and registrations reinstated under this section are subject to the same board authority under Minnesota Statutes, sections 148.10 and 214.103, as other applications and registrations issued by the board to deny, refuse to issue, revoke, suspend, condition, or limit a license or to take disciplinary or corrective action against a registrant or applicant for conduct that violates applicable law or professional standards.

Subd. 8. **Expiration.** This section expires on the date that rules adopted by the board removing the inactive status for chiropractic acupuncture registration reinstatement and establishing new chiropractic acupuncture registration reinstatement procedures become effective.

Sec. 27. **INTERIM ANIMAL CHIROPRACTIC REGISTRATION REINSTATEMENT PROCEDURES.**

Subdivision 1. **Scope.** This section applies to a chiropractor whose Minnesota animal chiropractic registration was canceled.

Subd. 2. **Application requirements.** At the time of application for reinstatement of an animal chiropractic registration, the applicant must:

(1) hold an active Minnesota chiropractic license;

(2) submit an application for reinstatement;

(3) pay the current renewal fee;

(4) submit license verification from each jurisdiction where the applicant holds or has held a chiropractic license; and

(5) complete any additional applicable requirements as established in subdivisions 3 and 4.

Subd. 3. **Reinstatement of canceled registration for registrant in good standing in another jurisdiction.** The Board of Chiropractic Examiners must reinstate the animal chiropractic registration of an applicant who holds an animal chiropractic credential that is equivalent to a Minnesota registration and in good standing in another jurisdiction if the applicant:

(1) completes all requirements in subdivision 2;

(2) provides verification of an animal acupuncture credential in good standing from each jurisdiction where the applicant is authorized to perform animal acupuncture; and

(3) provides verification of completing six continuing education units in animal chiropractic diagnosis and treatment in the year immediately preceding the application for reinstatement.

Subd. 4. **Reinstatement of canceled registration for registrant with no animal chiropractic credential in good standing in another jurisdiction.** The board must reinstate the registration of an applicant who does not meet the requirements of subdivision 3 if the applicant:

(1) completes all requirements in subdivision 2; and

(2) provides verification of completing six continuing education units related to animal chiropractic diagnosis and treatment for each year the applicant cannot verify an active animal chiropractic credential that is equivalent to a Minnesota registration and in good standing.

Subd. 5. **Continuing education in year of reinstatement.** A licensee must not use continuing education hours obtained for the purposes of applying for reinstatement of a

canceled registration under this section to meet the annual hour requirement for the year the license is reinstated.

Subd. 6. **Board authority.** Applications for reinstatement and registrations reinstated under this section are subject to the same board authority under Minnesota Statutes, sections 148.10 and 214.103, as other applications and registrations issued by the board to deny, refuse to issue, revoke, suspend, condition, or limit a license or to take disciplinary or corrective action against a registrant or applicant for conduct that violates applicable law or professional standards.

Subd. 7. **Expiration.** This section expires on the date that rules adopted by the board removing the inactive status for animal chiropractic registration reinstatement and establishing new animal chiropractic registration reinstatement procedures become effective.

Sec. 28. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber each provision of Minnesota Statutes listed in column A to the number listed in column B. The revisor shall also make necessary cross-reference changes consistent with the renumbering:

Column A	Column B
148.01, subdivision 1a	148.032, subdivision 1
148.01, subdivision 1b	148.032, subdivision 2
148.01, subdivision 1c	148.032, subdivision 3
148.01, subdivision 1d	148.032, subdivision 4
148.032, paragraphs (a) and (b)	148.032, subdivision 5, paragraphs (a) and (b)
148.032, paragraphs (c) and (d)	148.032, subdivision 6, paragraphs (a) and (b)
148.032, paragraph (e)	148.032, subdivision 7

Sec. 29. **REPEALER.**

(a) Minnesota Statutes 2024, section 151.13, is repealed.

(b) Minnesota Rules, parts 2500.0100, subparts 5b, 6, and 12; 2500.1900; 2500.2020; 2500.2040; 2500.2100; 2500.2110; 6800.0400; and 6800.1150, are repealed.

ARTICLE 2
DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2025 Supplement, 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 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 62D.02, subdivision 7, is amended to read:

Subd. 7. **Comprehensive health maintenance services.** "Comprehensive health maintenance services" means a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, emergency ground ambulance transportation services, inpatient hospital and physician care, outpatient health services and preventive ~~health~~ items and services.

Sec. 3. Minnesota Statutes 2024, section 62D.02, is amended by adding a subdivision to read:

Subd. 18. **Service area.** "Service area" means the geographic locations where the health maintenance organization is approved by the commissioner to sell health maintenance organization products. Geographic locations shall be identified according to recognized political subdivisions such as cities, counties, and townships.

Sec. 4. Minnesota Statutes 2024, section 62D.08, subdivision 5, is amended to read:

Subd. 5. **Changes in participating entities; penalty.** Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a ~~provider~~ participating entity for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within ten working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Sec. 5. Minnesota Statutes 2024, section 62D.08, subdivision 6, is amended to read:

Subd. 6. **Quarterly financial statements.** (a) A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due

30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.

(b) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(c) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

Sec. 6. Minnesota Statutes 2024, section 62D.09, subdivision 1, is amended to read:

Subdivision 1. **Marketing requirements.** (a) Any written marketing materials which may be directed toward potential enrollees and which include a detailed description of benefits provided by the health maintenance organization shall include a statement of enrollee information and rights as described in section 62D.07, subdivision 3, clauses (2) and (3). Prior to any oral marketing presentation, the agent marketing the plan must inform the potential enrollees that any complaints concerning the material presented should be directed to the health maintenance organization, the commissioner of health, or, if applicable, the employer.

(b) Detailed marketing materials must affirmatively disclose all exclusions and limitations in the organization's services or kinds of services offered to the contracting party, including but not limited to the following types of exclusions and limitations:

(1) health care services not provided;

(2) health care services requiring co-payments or deductibles paid by enrollees;

(3) the fact that access to health care services does not guarantee access to a particular provider or provider type; and

(4) health care services that are or may be provided only by referral of a physician, advanced practice registered nurse, or physician assistant.

(c) No marketing materials may lead consumers to believe that all health care needs will be covered. All marketing materials must alert consumers to possible uncovered expenses with the following language in bold print: "THIS HEALTH CARE PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES; READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED." Immediately following the disclosure required under paragraph (b), clause (3), consumers must be given a telephone number to use to contact the health maintenance organization for specific information about access to provider types.

(d) The disclosures required in paragraphs (b) and (c) are not required on billboards or image, and name identification advertisement.

Sec. 7. Minnesota Statutes 2024, section 62D.09, subdivision 5, is amended to read:

Subd. 5. **Participating providers.** (a) Health maintenance organizations shall ~~provide enrollees with a list of the names and locations of participating providers to whom enrollees have direct access without referral no later than the effective date of enrollment or date the evidence of coverage is issued and upon request~~ publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to enrollees and potential enrollees. Health maintenance organizations need not provide the names of their employed providers. Health maintenance organizations must notify enrollees and potential enrollees of the provider directory and where it can be accessed.

(b) Upon request, a health maintenance organization shall provide a hard copy of the provider directory to enrollees or potential enrollees.

Sec. 8. Minnesota Statutes 2024, section 62D.124, subdivision 6, is amended to read:

Subd. 6. **Provider network notifications.** (a) A health maintenance organization must provide on the organization's website the provider network for each product offered by the organization, and must update the organization's website at least once a month with any changes to the organization's provider network, including provider changes from in-network status to out-of-network status. A health maintenance organization must also provide on the organization's website, for each product offered by the organization, a list of the current waivers of the requirements in subdivision 1 or 2, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health maintenance organization must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under paragraph (a), unless the health maintenance organization notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health maintenance organization is able to verify that the health maintenance organization's website displayed the correct provider network status on the health maintenance organization's website at the time the service was provided.

Sec. 9. Minnesota Statutes 2024, section 62J.17, subdivision 6a, is amended to read:

Subd. 6a. **Prospective review and approval.** (a) No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7.

(c) The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. ~~At the request of the commissioner, the health technology advisory committee shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner.~~ The commissioner shall make a decision on the application within 60 days after an application is received.

(d) The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Sec. 10. Minnesota Statutes 2024, section 62J.2930, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The commissioner of health shall establish an information clearinghouse within the Department of Health to facilitate the ability of consumers, employers, providers, health plan companies, and others to obtain information on health reform activities in Minnesota. The commissioner shall make available through the clearinghouse updates on federal and state health reform activities, including information developed or collected by the Department of Health on cost containment or other research initiatives, the development of voluntary purchasing pools, action plans submitted by health plan companies, reports or recommendations of ~~the Health Technology Advisory Committee and other~~ entities on technology assessments, and reports or recommendations from other formal committees applicable to health reform activities. The clearinghouse shall also refer requestors to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Sec. 11. Minnesota Statutes 2024, section 62J.497, subdivision 5, is amended to read:

Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, 2016, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

(d) Starting January 1, 2027, providers and group purchasers must exchange prescription drug prior authorization request transactions electronically using the NCPDP SCRIPT Standard.

Sec. 12. Minnesota Statutes 2024, section 62J.536, subdivision 2a, is amended to read:

Subd. 2a. **Group purchasers not covered by HIPAA.** ~~For transactions with~~ Group purchasers defined in section 62J.03, subdivision 6, that are not covered under United States Code, title 42, sections 1320d to 1320d-8, ~~the requirements of this section are modified as follows:~~ are exempt from the requirements of subdivision 1, paragraphs (a) and (b), to accept and transmit the eligibility for a health plan transaction described in Code of Federal Regulations, title 45, part 162, subpart L.

~~(1) The group purchasers may be exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1 if the commissioner of health determines that:~~

~~(i) a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or~~

~~(ii) another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.~~

~~(2) If group purchasers are exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1, providers shall also be exempt from exchanging those transactions with the group purchaser.~~

~~(3) If the commissioner of health exempts a group purchaser from one or more of the requirements because a transaction is incapable of exchanging data that are currently being exchanged on paper and are necessary to accomplish the purpose of the transaction, the commissioner shall review that exemption annually. If the commissioner determines that the exemption is no longer necessary or appropriate, the commissioner of health shall adopt rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (e). Group purchasers and providers shall have 12 months to implement any rules adopted.~~

~~(4) If the commissioner of health exempts a group purchaser from one or more of the requirements because another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction, the commissioner shall adopt rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the national electronic transaction standard. Group purchasers and providers shall have 12 months to implement any rules adopted.~~

~~(5) The requirement of paper claims attachments shall not indicate that a health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K, is incapable of exchanging data that are currently being exchanged on paper provided that the electronic health care claims transaction has a mechanism to link the paper attachments to the electronic claim.~~

Sec. 13. Minnesota Statutes 2025 Supplement, 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:

(1) a drug manufacturer licensed under section 151.252~~.~~; or

(2) an entity that sets the wholesale acquisition cost for prescription drugs that are distributed in Minnesota.

(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) "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.

(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.

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

(q) "Pricing unit" means a quantity of one of the ~~smallest dispensable amount of a prescription drug product that could be dispensed or administered~~ standard unit of measure, such as milliliter, gram, or each, of a prescription drug product.

(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.

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

(t) "Wholesale drug distributor" or "wholesaler" means an entity that is licensed to act as a wholesale drug distributor under section 151.47.

Sec. 14. Minnesota Statutes 2025 Supplement, 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;

(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;

(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;

(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;

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

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

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

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

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

(15) if a brand name prescription drug, the highest ~~price~~ amount paid for a drug product with the same generic drug description or nontrade name, dosage form, strength, and, where

available, package size of the prescription drug during the previous calendar year in the ten countries, excluding the United States, that charged the highest single ~~price~~ amount for the prescription drug~~; and~~. Where a package size equivalent is not available, the value provided should represent the amount paid per unit of measure of the drug product multiplied by the total package size in the United States of the prescription drug reported;

(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. 15. Minnesota Statutes 2025 Supplement, 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~~ at least annually 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.

Sec. 16. Minnesota Statutes 2025 Supplement, 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;

(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;

(6) the direct costs incurred during the 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;

(7) the number of units of the prescription drug sold during the reporting period specified in the notification to report;

(8) the total sales revenue for the prescription drug during the reporting period specified in the notification to report;

(9) the total rebate payable amount accrued for the prescription drug during the reporting period specified in the notification to report;

(10) the manufacturer's net profit attributable to the prescription drug during the reporting period specified in the notification to report;

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

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

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

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

(15) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest ~~prices~~ amounts for a drug product with the same generic drug description or nontrade name, dosage form, strength, and, where available, package size of the prescription drug during the previous calendar year and their ~~prices~~ amounts. Where a package size equivalent is not available, the value provided should represent the amount paid per unit of measure of the drug product multiplied by the total package size in the United States of the prescription drug reported; and

(16) if the prescription drug was acquired by the manufacturer within 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. 17. Minnesota Statutes 2025 Supplement, 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 pricing units of the drug acquired during the reporting period specified in the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the reporting period specified in the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the reporting period specified in the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the 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 reporting period specified in the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the 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 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. 18. Minnesota Statutes 2025 Supplement, 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 during the 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 during the reporting period specified in the notification to report;

(4) the total reimbursement 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) 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;

(6) the total rebate receivable amount accrued by the PBM for the drug product during the reporting period specified in the notification to report; ~~and~~

(7) the total rebate payable amount accrued by the PBM for the drug product during the reporting period specified in the notification to report~~.~~;

(8) the name of any entity, including but not limited to a group purchasing organization, that the PBM contracts with or owns, in part or in full, that negotiates rebates for the drug product during the reporting period specified in the notification to report;

(9) the total amount accrued and receivable from all organizations reported under clause (8) for the drug product during the reporting period specified in the notification to report; and

(10) of the amount reported under clause (9), the percentage that is accrued and payable to health plan companies or other entities for the drug product during the 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. 19. Minnesota Statutes 2025 Supplement, 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 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 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 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 reporting period specified in the notification to report;

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

(7) the total rebate payable amount accrued by the wholesale drug distributor for the drug product during the reporting period specified in the notification to report~~.~~;

(8) the name of any entity, including but not limited to a group purchasing organization that the wholesaler contracts with or owns, in part or in full, that negotiates rebates for the drug product during the reporting period specified in the notification to report;

(9) the total receivable amount accrued from all organizations reported under clause (8) for the drug product during the reporting period specified in the notification to report; and

(10) of the amount reported under clause (9), the percentage that is accrued and payable to other entities for the drug product during the 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. 20. Minnesota Statutes 2024, section 62K.02, subdivision 2, is amended to read:

Subd. 2. **Scope.** (a) This chapter applies only to health plans offered in the individual market or the small group market, including stand-alone dental plans sold on MNsure.

(b) This chapter applies to health carriers with respect to individual health plans and small group health plans, unless otherwise specified.

(c) If a health carrier issues or renews individual or small group health plans in other states, this chapter applies only to health plans issued or renewed in this state to a Minnesota resident, or to cover a resident of the state, or issued or renewed to a small employer that is actively engaged in business in this state, unless otherwise specified.

(d) This chapter does not apply to short-term coverage as defined in section 62A.65, subdivision 7, or grandfathered plan coverage as defined in section 62A.011, subdivision 1b.

Sec. 21. Minnesota Statutes 2024, section 62K.03, subdivision 6, is amended to read:

Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes stand-alone dental plans sold on MNsure.

Sec. 22. Minnesota Statutes 2024, section 62K.075, is amended to read:

62K.075 PROVIDER NETWORK NOTIFICATIONS.

(a) A health carrier must provide on the carrier's website the provider network for each product offered by the carrier, and must update the carrier's website at least once a month with any changes to the carrier's provider network, including provider changes from in-network status to out-of-network status. A health carrier must also provide on the carrier's website, for each product offered by the carrier, a list of the current waivers of the requirements in section 62K.10, subdivision 2 ~~or 3~~, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health carrier must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under paragraph (a) unless the health carrier notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health carrier is able to verify that the health carrier's website displayed the correct provider network status on the health carrier's website at the time the service was provided.

(c) The limitations of section 62Q.56, subdivision 2a, shall apply to payments required by paragraph (b).

Sec. 23. Minnesota Statutes 2025 Supplement, section 62K.10, subdivision 2, is amended to read:

Subd. 2. **Time and distance standards.** Health carriers must meet the time and distance standards under Code of Federal Regulations, title 45, section 155.1050, for all covered health services, including dental, retail pharmacy, and specialty services.

Sec. 24. Minnesota Statutes 2024, section 62K.105, is amended to read:

62K.105 NETWORK ADEQUACY COMPLAINTS.

The commissioner of health shall establish a clear, easily accessible process for accepting complaints from enrollees regarding health carrier compliance with section 62K.10, subdivision 2~~, 3,~~ or 4. Using this process, an enrollee may file a complaint with the commissioner that a health carrier is not in compliance with the requirements of section 62K.10, subdivision 2~~, 3,~~ or 4. The commissioner of health shall investigate all complaints received under this section.

Sec. 25. Minnesota Statutes 2024, section 62K.14, is amended to read:

62K.14 LIMITED-SCOPE PEDIATRIC DENTAL PLANS.

(a) Limited-scope pediatric dental plans must be offered to the extent permitted under the Affordable Care Act: (1) on a guaranteed issue and guaranteed renewable basis; (2) with premiums rated on allowable rating factors used for health plans; and (3) without any exclusions or limitations based on preexisting conditions.

(b) Notwithstanding paragraph (a), a health carrier may discontinue a limited scope pediatric dental plan at the end of a plan year if the health carrier provides written notice to enrollees before coverage is to be discontinued that the particular plan is being discontinued and the health carrier offers enrollees other dental plan options that are the same or substantially similar to the dental plan being discontinued in terms of premiums, benefits, cost-sharing requirements, and network adequacy. The written notice to enrollees must be provided at least 105 days before the end of the plan year.

~~(c) Limited-scope pediatric dental plans must ensure primary care dental services are available within 60 miles or 60 minutes' travel time.~~

~~(d)~~ (c) If a stand-alone dental plan as defined under the Affordable Care Act or a limited-scope pediatric dental plan is offered, either separately or in conjunction with a health plan offered to individuals or small employers, the health plan shall not be considered in noncompliance with the requirements of the essential benefit package in the Affordable Care Act because the health plan does not offer coverage of pediatric dental benefits if these benefits are covered through the stand-alone or limited-scope pediatric dental plan, to the extent permitted under the Affordable Care Act.

~~(e)~~ (d) Health carriers offering limited-scope pediatric dental plans must comply with this section and sections 62K.07, 62K.08, 62K.10, 62K.13, and 62K.15.

~~(f)~~ (e) The commissioner of commerce shall enforce paragraphs (a) and (b). Any limited-scope pediatric dental plan that is to be offered to replace a discontinued dental plan under paragraph (b) must be approved by the commissioner of commerce in terms of cost and benefit similarity, and the commissioner of health in terms of network adequacy similarity. ~~The commissioner of health shall enforce paragraph (c).~~

Sec. 26. Minnesota Statutes 2024, section 62M.07, subdivision 2, is amended to read:

Subd. 2. **Prior authorization of certain services prohibited.** No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of:

(1) emergency confinement or an emergency service. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon as reasonably possible after the beginning of the emergency confinement or emergency service;

(2) outpatient mental health treatment or outpatient substance use disorder treatment, except for treatment which is a medication. Prior authorizations required for medications used for outpatient mental health treatment or outpatient substance use disorder treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(3) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network, except for treatment which is a medication. Prior authorizations required for medications used for antineoplastic cancer treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(4) services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations ~~recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention~~ required to be covered under section 62Q.46, or preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130;

(5) pediatric hospice services provided by a hospice provider licensed under sections 144A.75 to 144A.755; and

(6) treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

Clauses (2) to (6) are effective January 1, 2026, and apply to health benefit plans offered, sold, issued, or renewed on or after that date.

Sec. 27. Minnesota Statutes 2024, section 62Q.46, subdivision 1, is amended to read:

Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and services" has the meaning specified in the Affordable Care Act. Preventive items and services includes:

(1) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults that have in effect at least one of the following:

(i) a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this ~~clause~~ item, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after the recommendation has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if the recommendation is listed on the Immunization Schedules of the Centers for Disease Control and Prevention; or

(ii) a recommendation from at least one of the following organizations: the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Academy of Family Physicians, or the Infectious Disease Society of America. This item does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(4) with respect to women, additional preventive care and screenings that are not listed with a rating of A or B by the United States Preventive Services Task Force but that are provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(5) all contraceptive methods established in guidelines published by the United States Food and Drug Administration;

(6) screenings for human immunodeficiency virus for:

(i) all individuals at least 15 years of age but less than 65 years of age; and

(ii) all other individuals with increased risk of human immunodeficiency virus infection according to guidance from the Centers for Disease Control;

(7) all preexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention of HIV Infection United States Preventive Services Task Force Recommendation Statement; and

(8) all postexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control.

(b) A health plan company must provide coverage for preventive items and services at a participating provider without imposing cost-sharing requirements, including a deductible, coinsurance, or co-payment. Nothing in this section prohibits a health plan company that has a network of providers from excluding coverage or imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

(c) A health plan company is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (a) if the recommendation or guideline is no longer included as a preventive item or service as defined in paragraph (a). Annually, a health plan company must determine whether any additional items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered.

(d) Nothing in this section prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent not specified in the recommendation or guideline.

(e) A health plan shall not require prior authorization or step therapy for preexposure prophylaxis or postexposure prophylaxis, except that: if the United States Food and Drug Administration has approved one or more therapeutic equivalents of a drug, device, or

product for the prevention of HIV, this paragraph does not require a health plan to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy.

(f) This section does not apply to grandfathered plans.

(g) This section does not apply to plans offered by the Minnesota Comprehensive Health Association.

Sec. 28. Minnesota Statutes 2024, section 144.059, subdivision 8, is amended to read:

Subd. 8. **Duties.** (a) The council shall consult with and advise the commissioner on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in the state.

(b) By February 15 of each odd-numbered year, the council shall submit to the chairs and ranking minority members of the committees of the senate and the house of representatives with primary jurisdiction over health care a report containing:

(1) the advisory council's assessment of the availability of palliative care in the state;

(2) the advisory council's analysis of barriers to greater access to palliative care; and

(3) recommendations for legislative action, with draft legislation to implement the recommendations.

(c) The Department of Health shall publish the report ~~each year~~ on the department's website.

Sec. 29. Minnesota Statutes 2024, section 144.293, subdivision 7, is amended to read:

Subd. 7. **Exception to consent.** Subdivision 2 does not apply to the release of health records to the commissioner of health ~~or the Health Data Institute under chapter 62J~~, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Sec. 30. Minnesota Statutes 2024, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site

to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal

health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution does not involve the construction of a new hospital building; and (v) the transferred beds are used first to replace within the hospital corporate system the total number of beds previously used in the closed facility site or complex for mental health services and substance use disorder services. Only after the hospital corporate system has fulfilled the requirements of this item may the remainder of the available capacity of the closed facility site or complex be transferred for any other purpose;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 100 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the Direct Care and Treatment executive board to a new or existing facility, building, or complex operated by the Direct Care and Treatment executive board; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital 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 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission;

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as ~~designated~~ regulated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added;

(29) upon submission of a plan to the commissioner for public interest review under section 144.552 and the addition of the 15 inpatient mental health beds specified in clause (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as ~~designated~~ regulated under section 383A.91, subdivision 5. Five of the 45 additional beds authorized under this clause must be designated for use for inpatient mental health and must be added to the hospital's bed capacity before the remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552;

(30) upon submission of a plan to the commissioner for public interest review under section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital

in Hennepin County that exclusively provides care to patients who are under 21 years of age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for the public interest review described in section 144.552;

(31) any project to add licensed beds in a hospital located in Cook County or Mahnomen County that: (i) is designated as a critical access hospital under section 144.1483, clause (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of licensed beds in the hospital after the bed addition does not exceed 25 beds. Notwithstanding section 144.552, a public interest review is not required for a project authorized under this clause;

(32) upon submission of a plan to the commissioner for public interest review under section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's hospital in St. Paul that is part of an independent pediatric health system with freestanding inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add licensed beds under this clause prior to completion of the public interest review, provided the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public interest review described in section 144.552;

(33) a project for a 144-bed psychiatric hospital on the site of the former Bethesda hospital in the city of Saint Paul, Ramsey County, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete. Following the completion of the construction project, the commissioner of health shall monitor the hospital, including by assessing the hospital's case mix and payer mix, patient transfers, and patient diversions. The hospital must have an intake and assessment area. The hospital must accommodate patients with acute mental health needs, whether they walk up to the facility, are delivered by ambulances or law enforcement, or are transferred from other facilities. The hospital must comply with subdivision 1a, paragraph (b). The hospital must annually submit de-identified data to the department in the format and manner defined by the commissioner; ~~or~~

(34) a project involving the relocation of up to 26 licensed long-term acute care hospital beds from an existing long-term care hospital located in Hennepin County with a licensed capacity prior to the relocation of 92 beds to dedicated space on the campus of an existing safety net, level I trauma center hospital in Ramsey County as ~~designated~~ regulated under

section 383A.91, subdivision 5, provided both the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete and the relocated beds continue to be used as long-term acute care hospital beds after the relocation.; or

(35) a project to add 85 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as regulated under section 383A.91, subdivision 5.

Sec. 31. Minnesota Statutes 2024, section 145.56, subdivision 5, is amended to read:

Subd. 5. **Periodic evaluations; biennial reports.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. ~~By July 1, 2002, and~~ On July 1 of each even-numbered year ~~thereafter~~, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house of representatives and senate with jurisdiction over health and human services issues.

Sec. 32. Minnesota Statutes 2024, section 145.561, subdivision 2, is amended to read:

Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the state 24 hours per day, seven days per week.

(b) The designated 988 Lifeline Center must:

(1) have an active agreement with the 988 Suicide and Crisis Lifeline program for participation in the network and the department;

(2) meet the 988 Lifeline program requirements and best practice guidelines for operational and clinical standards;

(3) provide data and reports, and participate in evaluations and related quality improvement activities as required by the 988 Lifeline program and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across mobile crisis and public safety answering points used in the state for the purpose of crisis care coordination;

(5) facilitate crisis and outgoing services, including mobile crisis teams in accordance with guidelines established by the 988 Lifeline program and the department;

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers, local community mental health centers including certified community behavioral health clinics and community behavioral health centers, mobile crisis teams, and community based and hospital emergency departments;

(7) offer follow-up services to individuals accessing the 988 Lifeline Center that are consistent with guidance established by the 988 Lifeline program and the department; and

(8) meet the requirements set by the 988 Lifeline program and the department for serving at-risk and specialized populations.

(c) The commissioner shall adopt rules to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The commissioner, having primary oversight of suicide prevention, shall work with the 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the purpose of ensuring consistency of public messaging about 988 services.

(e) The commissioner shall work with representatives from 988 Lifeline Centers and public safety answering points, other public safety agencies, and the commissioner of public safety to facilitate the development of protocols and procedures for interactions between 988 and 911 services across Minnesota. Protocols and procedures shall be developed following available national standards and guidelines.

(f) The commissioner shall provide ~~an annual~~ a biennial public report on 988 Lifeline usage by July 1 of each even-numbered year, including data on answer rates, abandoned calls, and referrals to 911 emergency response. The biennial report may be included as a section within the state suicide prevention report required under section 145.56.

Sec. 33. Minnesota Statutes 2024, section 145.882, is amended by adding a subdivision to read:

Subd. 9. **Contracting and procurement.** The commissioner is exempt from the contract term limits in chapter 16C for issuance of benefits under the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) through an electronic benefit transfer (EBT) system and related services and contracts. The contracts may have an initial term of up to five years, with extensions not to exceed a ten-year total contract duration.

Sec. 34. Minnesota Statutes 2024, section 145.882, is amended by adding a subdivision to read:

Subd. 10. **Management information systems; contracting and procurement.** Notwithstanding chapter 16C, WIC is exempt from the contract term limits for the management information systems used for issuance of supplemental nutrition benefits and the WIC EBT systems used for processing the redemptions of supplemental nutrition benefits. The contracts may have an initial term of up to five years, with extensions not to exceed a ten-year total contract duration.

Sec. 35. Minnesota Statutes 2024, section 145A.04, subdivision 15, is amended to read:

Subd. 15. **State and local advisory committees.** (a) A state community health services advisory committee is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, funding, and evaluation of local and Tribal public health services. Each community health board may appoint a member to serve on the committee. Each of Minnesota's federally recognized Tribal Nations may appoint a member to the advisory committee established under this section. The committee must meet at least quarterly, and special meetings may be called by the committee chair or a majority of the members. A Tribal Nation may elect to participate at any time. Members or their alternates may be reimbursed for travel and other necessary expenses while engaged in their official duties.

(b) Notwithstanding section 15.059, the State Community Health Services Advisory Committee does not expire.

(c) The city boards or county boards that have established or are members of a community health board may appoint a community health advisory committee to advise, consult with, and make recommendations to the community health board on the duties under subdivision 1a.

Sec. 36. Minnesota Statutes 2024, section 148.517, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** An applicant who applies for licensure as a speech-language pathologist or audiologist by reciprocity must meet the requirements of subdivisions 2 and 3. An applicant who applies for licensure as an audiologist by reciprocity must pass the practical exam required under section 148.515, subdivision 6.

Sec. 37. Minnesota Statutes 2024, section 148.517, subdivision 2, is amended to read:

Subd. 2. **Current credentials required.** An applicant applying for licensure by reciprocity must provide evidence to the commissioner that the applicant holds a current and unrestricted credential for the practice of speech-language pathology or audiology in another jurisdiction that has requirements equivalent to or higher than those in effect for determining whether an applicant in this state is qualified to be licensed as a speech-language pathologist or audiologist. An applicant who provides sufficient evidence need not meet the requirements of section 148.515, except for subdivision 6, provided that the applicant otherwise meets all other requirements of section 148.514.

Sec. 38. Minnesota Statutes 2024, section 148.5191, subdivision 4, is amended to read:

Subd. 4. **Renewal deadline.** Each license, including a temporary license provided under section 148.5161, must state an expiration date. An application for licensure renewal must be received by the Department of Health ~~or postmarked~~ at least 30 days before the expiration date. ~~If the postmark is illegible, the application shall be considered timely if received at least 21 days before the expiration date.~~

When the commissioner establishes the renewal schedule for an applicant, licensee, or temporary licensee, if the period before the expiration date is less than two years, the fee shall be prorated.

Sec. 39. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 62Q.075, as Minnesota Statutes, section 62D.081. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

Sec. 40. **REPEALER.**

Minnesota Statutes 2024, sections 13D.08, subdivision 4; 62D.08, subdivision 7; 62D.181; 62J.06; 62J.156; 62J.2930, subdivision 4; 62J.57; and 144.9821, are repealed.

ARTICLE 3
HUMAN SERVICES HEALTH CARE

Section 1. Minnesota Statutes 2024, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets meets the definition of disabled under the Supplemental Security Income program; and

(2) pays a premium and other obligations under paragraph (d).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income, be receiving an unemployment insurance benefit under chapter 268 that the person began receiving while eligible under this subdivision, or be receiving family and medical leave benefits under chapter 268B that the person began receiving while eligible under this subdivision. A person who is self-employed must file and pay all applicable taxes. Any spousal income shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who would otherwise be ineligible and be disenrolled due to one of the following circumstances may retain eligibility for up to four consecutive months after a month of job loss if the person:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, advanced practice registered nurse, or physician assistant; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income.

To receive a four-month extension of continued eligibility under this paragraph, enrollees must verify the medical condition or provide notification of job loss, continue to meet all other eligibility requirements, and continue to pay all calculated premium costs.

(d) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(e) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(f) Any required premium shall be determined at application and redetermined at the enrollee's 12-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within 30 days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next 12-month review.

(g) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. The commissioner must not determine that good cause exists for a month for which the premium has already been paid. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(i) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the

enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

(j) The commissioner is authorized to determine that a premium amount was calculated or billed in error, make corrections to financial records and billing systems, and refund premiums collected in error.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 4, is amended to read:

Subd. 4. **Outpatient and physician-directed clinic services.** Medical assistance covers outpatient hospital or physician-directed clinic services. ~~The~~ All services provided by physician-directed clinic staff ~~shall include at least two physicians and all services shall~~ must be ~~provided~~ under the ~~direct supervision~~ direction of a physician. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. "Emergency services" means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 3. Minnesota Statutes 2025 Supplement, section 256B.695, subdivision 5, is amended to read:

Subd. 5. **CARMA enrollment.** (a) Subject to ~~paragraphs~~ paragraph (d) ~~and (e)~~, eligible individuals must be automatically enrolled in CARMA, but may decline enrollment. Eligible individuals may enroll in fee-for-service medical assistance. Eligible individuals may change their CARMA elections on an annual basis.

(b) Eligible individuals must be able to enroll in CARMA through the selection process in accordance with the election period established in section 256B.69, subdivision 4, paragraph (e).

(c) Enrollees who were not previously enrolled in the medical assistance program or MinnesotaCare can change their selection once within the first year after enrollment in CARMA. Enrollees who were not previously enrolled in CARMA have 90 days to make a change and changes are allowed for additional special circumstances.

(d) The commissioner may not offer a second health plan to eligible individuals other than, ~~and~~ or in addition to, CARMA except that the commissioner may offer a second health plan to eligible individuals ~~when another health plan is~~ enrolling in MinnesotaCare, if required by federal law or rule. Eligible individuals who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.

(e) The commissioner may offer a replacement plan to eligible individuals, as determined by the commissioner, when counties administering CARMA have their contract terminated for cause.

~~(e)~~ (f) The commissioner may, on a county-by-county basis, offer a health plan other than~~, and in addition to,~~ CARMA to individuals who are eligible for both Medicare and medical assistance due to age, income, or disability if ~~the commissioner deems it necessary for enrollees to have another choice of health plan. Factors the commissioner must consider when determining if the other health plan is necessary include the number of available Medicare Advantage Plan options that are not special needs plans in the county, the size of the enrolling population, the additional administrative burden placed on providers and counties by multiple health plan options in a county, the need to ensure the viability and success of the CARMA program, and the impact to the medical assistance program~~ there is not already a health plan available under CARMA.

~~(f) In counties where the commissioner is required by federal law or elects to offer a second health plan other than CARMA pursuant to paragraphs (d) and (e), eligible enrollees who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.~~

(g) This subdivision supersedes section 256B.694.

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

Sec. 4. Minnesota Statutes 2024, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported.

All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, ~~subdivision~~ subdivisions 1~~, paragraph (c)~~ and 2, is the first day of the month following the month in which eligibility is approved.

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

Sec. 5. Minnesota Statutes 2024, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain ~~eligibility~~ coverage in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month following the month for which the premium was due. Persons disenrolled for nonpayment may not reenroll prior to the first day of the month following the payment of an amount equal to ~~two months' premiums~~ one monthly premium.

(e) The commissioner shall forgive the past-due premium for persons disenrolled under paragraph (d) prior to issuing a premium invoice for the ~~fourth~~ next month ~~following disenrollment~~.

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

Sec. 6. Laws 2024, chapter 125, article 4, section 12, subdivision 5, is amended to read:

Subd. 5. **Report.** By ~~December 15, 2025~~ November 30, 2026, the commissioner must provide a summary report on the pilot program to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and county correctional facilities.

EFFECTIVE DATE. This section is effective retroactively from December 15, 2025.

ARTICLE 4
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2025 Supplement, section 245.469, subdivision 1, is amended to read:

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 and emergency service providers must not delay or deny the timely provision of emergency services to a client due to payor source for the services provided. Emergency service providers must 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.

Sec. 2. Minnesota Statutes 2025 Supplement, 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 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 mental illness or serious mental illness who are at risk of residential treatment or hospitalization; who are already in residential treatment or therapeutic foster care or in family foster settings as defined in chapter 142B and at risk of change in 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 under section 245.4908;

(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;

(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. 3. **[245.4908] EARLY CHILDHOOD MENTAL HEALTH CONSULTATION GRANTS.**

Subdivision 1. **Establishment.** The commissioner of human services must establish an early childhood mental health consultation grant program to support the delivery of specialized mental health care to children five years of age or younger. The care may include providing mental health consultation to child care professionals for the development of knowledge and skills to provide child care to young children with significant mental health needs.

Subd. 2. **Eligible applicants; third-party reimbursement.** (a) An applicant is eligible for an early childhood mental health consultation grant under this section if the applicant 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; or

(4) a provider of children's therapeutic services and supports, as defined in section 256B.0943.

(b) Grantees must obtain all available third-party reimbursement sources as a condition of receiving a grant.

Subd. 3. **Allowable grant activities and related expenses.** Grant money must be used to provide early childhood mental health consultation, including but not limited to:

(1) identifying and diagnosing mental health conditions for children five years of age or younger;

(2) training clinicians on evidence-based or evidence-informed clinical practices for children five years of age or younger and their caregivers, including train-the-trainer models to build capacity for grantees to train staff. The commissioner may recommend specific clinical practices, modalities, and trainings under this clause;

(3) providing direct consultation to child care providers in licensed child care centers, Head Start, and licensed family child care settings; and

(4) family psychoeducation and individual and group skills for families of children receiving early childhood mental health services.

Subd. 4. **Data collection and outcome measurement.** (a) The commissioner must consult with grantees to develop ongoing outcome measures for program capacity and performance.

(b) Upon the commissioner's request, grantees must provide the data required under paragraph (c) and may provide the data requested under paragraph (d) to the commissioner for the purpose of evaluating the effectiveness of the grant program. The commissioner must not request data from grantees more than twice per year.

(c) Grantees must provide the following quantitative data to the commissioner:

(1) number of clients served;

(2) client demographics;

(3) payor information; and

(4) client-related clinical and ancillary services, including hours of direct client services and hours of consultation provided in child care settings.

(d) Grantees may collect and provide qualitative data to the commissioner to demonstrate outcomes.

(e) By July 1, 2027, 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. The report must include the number of grantees receiving grant money 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 money for the services provided under this section. This paragraph expires June 30, 2037.

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

Sec. 4. Minnesota Statutes 2024, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the website, email, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice in the community;

(14) personal privacy, including the right to use the lock on the person's bedroom or unit door;

(15) engage in chosen activities; and

(16) access to the person's personal possessions at any time, including financial resources.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;

(5) have access to three nutritionally balanced meals and nutritious snacks between meals each day;

(6) have freedom and support to access food and potable water at any time;

(7) have the freedom to furnish and decorate the person's bedroom or living unit;

(8) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(9) a setting that is free from hazards that threaten the person's health or safety; and

(10) a setting that meets the definition of a dwelling unit within a residential occupancy as defined in the State Fire Code.

(c) Except as provided under subdivision 4, restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's support plan or support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Sec. 5. Minnesota Statutes 2024, section 245D.04, is amended by adding a subdivision to read:

Subd. 4. **Rights of minor children.** (a) For the purposes of this subdivision:

(1) "developmentally appropriate" means, for a person under 18 years of age, activities or items that are determined to be developmentally appropriate based on the development of a person's cognitive, emotional, physical, and behavioral capacities that are typical for the person's age or age group; and

(2) "reasonable and prudent parenting" means, for a person under 18 years of age, the standards characterized by careful and sensible parenting decisions that maintain a person's health and safety; cultural, religious, and Tribal values; and best interests while encouraging the person's emotional and developmental growth.

(b) A person under 18 years of age who is receiving services under this chapter has a right to:

(1) participate in activities or events that are generally accepted as suitable for minor children of the same chronological age or are developmentally appropriate; and

(2) receive reasonable and prudent parenting.

(c) Restriction of the rights under subdivision 3, paragraph (a), clauses (13) to (16), or (b), clauses (1) to (4), for a person under 18 years of age is allowed only if determined necessary to ensure the health, safety, and well-being of the person or pursuant to reasonable and prudent parenting standards.

Sec. 6. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended to read:

Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment supervision of a mental health professional, a mental health behavioral aide may practice psychosocial skills with a child client according to the child's treatment plan ~~and individual behavior plan~~ that a mental health professional, clinical trainee, or behavioral health practitioner has previously taught to the child.

Sec. 7. Minnesota Statutes 2024, section 245I.04, is amended by adding a subdivision to read:

Subd. 20. **Limitation on affiliation across service lines.** (a) A mental health professional must not simultaneously serve in a clinical, supervisory, or designated role for more than ten distinct, licensed provider organizations or service lines that deliver services in the medical assistance program. A mental health professional must not provide clinical or administrative supervision to more than 20 direct care or clinical staff across all affiliated provider organizations and service lines, unless an exception is granted by the commissioner under paragraph (c).

(b) The commissioner must establish criteria and a standardized process for evaluating exception requests under paragraph (c).

(c) Upon written request, the commissioner may grant an exception if the requester demonstrates that:

(1) the mental health professional can effectively meet all clinical, supervisory, and administrative responsibilities across affiliated programs;

(2) the oversight of client care will not be compromised; and

(3) the proposed arrangement complies with all applicable supervision, documentation, and service delivery requirements.

(d) In determining whether to grant an exception under paragraph (c), the commissioner must consider:

(1) the geographic distribution of services;

(2) the complexity and acuity of client needs;

(3) the mental health professional's other responsibilities, including direct service provision; and

(4) whether adequate supervision can be maintained in compliance with program standards.

(e) The commissioner must rescind approval of an exception granted under paragraph (c) if the requester fails to comply with applicable program standards or with the terms of the exception.

(f) A mental health professional determined to be in violation of this subdivision may be subject to corrective action, licensing sanctions, or administrative penalties in accordance with chapter 245A and other applicable law.

Sec. 8. Minnesota Statutes 2024, section 245I.08, subdivision 4, is amended to read:

Subd. 4. **Progress notes.** A license holder must use a progress note to document each occurrence of a mental health service that a staff person provides to a client. A progress note must include the following:

(1) the type of service;

(2) the date of service;

(3) the start and stop time of the service unless the license holder is licensed as a residential program;

(4) the location of the service;

(5) the scope of the service, including: (i) the targeted goal and objective; (ii) the intervention that the staff person provided to the client and the methods that the staff person used; (iii) the client's response to the intervention; and (iv) the staff person's plan to take future actions, including changes in treatment that the staff person will implement if the intervention was ineffective;

(6) the signature and credentials of the staff person who provided the service to the client;

(7) the dated signature and credentials of the treatment supervisor;

~~(7)~~ (8) the mental health provider travel documentation required by section 256B.0625, if applicable; and

~~(8)~~ (9) significant observations by the staff person, if applicable, including: (i) the client's current risk factors; (ii) emergency interventions by staff persons; (iii) consultations with or referrals to other professionals, family, or significant others; and (iv) changes in the client's mental or physical symptoms.

Sec. 9. Minnesota Statutes 2025 Supplement, 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 behavioral 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 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, excluding weekends and holidays, 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. 10. Minnesota Statutes 2025 Supplement, 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 commissioner 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.0505, subdivision 1, 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 9505.0140;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1272; 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 the commissioner 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.0501, subdivision 3.

(i) Notwithstanding any laws to the contrary, persons enrolled in MinnesotaCare or medical assistance are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section 256B.0632 and chapter 245I.

(j) A person is eligible for one 60-consecutive-calendar-day period per year. A person may submit a request for additional eligibility to the commissioner. A person denied additional eligibility under this paragraph may request a state agency hearing under section 256.045.

Sec. 11. Minnesota Statutes 2024, section 256B.0624, subdivision 6b, is amended to read:

Subd. 6b. **Crisis intervention services.** (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be providing face-to-face crisis intervention services. If providing crisis intervention services, a clinical trainee or mental health practitioner must seek treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(c) The mobile crisis intervention team must develop a crisis treatment plan according to subdivision 11.

(d) The mobile crisis intervention team must document which crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

(e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

~~(f) If the recipient's mental health crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.~~

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 12. Minnesota Statutes 2024, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis treatment plan must be developed that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8;

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis treatment plan, skills training, and collaboration with other service providers in the community; ~~and~~

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent~~.~~; and

(5) for a recipient who is 18 years of age or older, the case manager or crisis team must offer to work with the recipient to develop a health care directive, as defined in section 145C.01, subdivision 5a, or a declaration of preferences under section 253B.03, subdivision

6d, if the recipient's mental health crisis is stabilized and the recipient does not have a directive or declaration.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The commissioner ~~shall~~ must establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider ~~shall~~ must not exceed the rate charged by that provider for the same service to other payers. Payment ~~shall~~ must not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner ~~shall~~ must set rates prospectively for the annual rate period. The commissioner ~~shall~~ must require providers to submit annual cost reports on a uniform cost reporting form and ~~shall~~ must use submitted cost reports to inform the rate-setting process. The commissioner ~~shall~~ must recalculate the statewide per diem every year.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

(b) The commissioner ~~shall~~ must reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner ~~shall~~ must include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner ~~shall~~ must ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate ~~shall~~ must be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits

not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment ~~shall~~ must be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735, subdivision 3, ~~shall~~ must be established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner ~~shall~~ must rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services~~. For CCBHCs certified after September 30, 2020, and before January 1, 2021, the commissioner shall rebase rates according to this clause for services provided on or after January 1, 2024~~;

(5) the commissioner ~~shall~~ must provide for a 60-day appeals process after notice of the results of the rebasing;

(6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology;

(7) payments for CCBHC services to individuals enrolled in managed care ~~shall~~ must be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner ~~shall~~ must complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC ~~shall~~ must be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update ~~shall~~ must occur each year in between rebasing periods determined by the

commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope ~~shall~~ must occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans ~~shall~~ must reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner ~~shall~~ must monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner ~~shall~~ must implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC ~~shall~~ must receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC ~~shall~~ must receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner

~~shall~~ must notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section ~~shall~~ must be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims ~~shall~~ must be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims ~~shall~~ must be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC certified under section 245.735 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2).

Sec. 14. Minnesota Statutes 2024, section 256B.0625, subdivision 47, is amended to read:

Subd. 47. **Treatment foster care services.** ~~Effective July 1, 2011, and subject to federal approval,~~ Medical assistance covers ~~treatment foster care~~ children's intensive behavioral health services according to section 256B.0946.

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

Sec. 15. Minnesota Statutes 2025 Supplement, 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 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~~ two or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

(g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered services through telehealth as defined under section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

(i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

(j) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan ~~and individual behavior plan~~. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

(l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

(m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

(o) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given in section 245.4871, subdivision 15, for children under 18 years of age.

(p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

(q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

(r) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of

psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(t) "Treatment supervision" means the supervision described in section 245I.06.

Sec. 16. Minnesota Statutes 2024, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every ~~three~~ two years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment. When required components of the standard diagnostic assessment are not provided in an outside or independent assessment or cannot be attained immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the information into the child's individual treatment plan;

(2) developing an individual treatment plan;

(3) providing treatment supervision plans for staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation;

(4) requiring a mental health professional to determine the level of supervision for a behavioral health aide and to document and sign the supervision determination in the behavioral health aide's supervision plan;

(5) ensuring the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family.

Sec. 17. Minnesota Statutes 2025 Supplement, 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 at least one of 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~~ two to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

(iv) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(v) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If

upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

Sec. 18. Minnesota Statutes 2024, section 256B.0946, subdivision 4, is amended to read:

Subd. 4. **Service delivery payment requirements.** (a) To be eligible for payment under this section, a provider must develop and practice written policies and procedures for children's intensive behavioral health services, consistent with subdivision 1, paragraph (b), and comply with the following requirements in paragraphs (b) to (n).

(b) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the standard diagnostic assessment and team consultation and treatment planning review process.

(c) Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(d) The level of care assessment as defined in section 245I.02, subdivision 19, and functional assessment as defined in section 245I.02, subdivision 17, must be updated at least every 180 days or prior to discharge from the service, whichever comes first.

(e) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and approved every 180 days using the team consultation and treatment planning process.

(f) Clinical care consultation must be provided in accordance with the client's individual treatment plan.

(g) Each client must have a crisis plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(h) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week. If the mental health professional, client, and family agree, service units may be temporarily reduced for a period of no more than 60 days in order to meet the needs of the client and family, or as part of transition or on a discharge plan to another service or level of care. The reasons for service reduction must be identified~~,~~ and documented~~, and included~~ in the treatment plan or case file. Billing and payment are prohibited for days on which no services are delivered and documented.

(i) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(j) Treatment must be developmentally and culturally appropriate for the client.

(k) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects.

(l) Parents, siblings, foster parents, legal guardians, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(m) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

(n) In order for a provider to receive the daily per-client encounter rate, at least one of the services listed in subdivision 1, paragraph (b), clauses (1) to (3), must be provided. The services listed in subdivision 1, paragraph (b), clauses (4) and (5), may be included as part of the daily per-client encounter rate.

Sec. 19. Minnesota Statutes 2025 Supplement, 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 (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~~ qualified provider;

(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.

EFFECTIVE DATE. This section is effective July 1, 2027, or upon federal approval, whichever is later.

Sec. 20. Minnesota Statutes 2024, section 256B.0947, subdivision 5, is amended to read:

Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services must meet the standards in this section and chapter 245I as required in section 245I.011, subdivision 5.

(b) The treatment team must have specialized training in providing services to the specific age group of youth that the team serves. An individual treatment team must serve youth who are: (1) at least eight years of age or older and under 16 years of age~~, or~~; (2) at least 14 years of age or older and under 21 years of age; or (3) if a treatment team demonstrates to the commissioner expertise in meeting the developmental and clinical needs of an expanded age range, at least eight years of age or older and under 21 years of age.

(c) The treatment team for intensive nonresidential rehabilitative mental health services comprises both permanently employed core team members and client-specific team members as follows:

(1) Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include:

(i) a mental health professional who serves as team leader to provide administrative direction and treatment supervision to the team;

(ii) ~~an advanced-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist, either of which must be credentialed to prescribe medications~~ a psychiatric care provider who is credentialed to prescribe medications and who is either an advanced practice registered nurse with advanced education and training in psychiatric and mental health care or a board-certified psychiatrist. The psychiatric care provider must have demonstrated clinical experience and qualifications for working with children and adolescents with serious mental illness and co-occurring mental illness and substance use disorders;

(iii) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10, and is also a former children's mental health consumer; and

(iv) a co-occurring disorder specialist who meets the requirements under section 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the provision of co-occurring disorder treatment to clients.

(2) The core team may also include any of the following:

(i) additional mental health professionals;

(ii) a vocational specialist;

(iii) an educational specialist with knowledge and experience working with youth regarding special education requirements and goals, special education plans, and coordination of educational activities with health care activities;

(iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

(v) a clinical trainee qualified according to section 245I.04, subdivision 6;

(vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(vii) a case management service provider, as defined in section 245.4871, subdivision 4;

(viii) a housing access specialist; ~~and~~

(ix) a family peer specialist as defined in subdivision 2, paragraph (j)~~.~~; and

(x) a registered nurse, as defined in section 148.171, subdivision 20.

(3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc members not employed by the team who consult on a specific client and who must accept overall clinical direction from the treatment team for the duration of the client's placement with the treatment team and must be paid by the provider agency at the rate for a typical session by that provider with that client or at a rate negotiated with the client-specific member. Client-specific treatment team members may include:

(i) the mental health professional treating the client prior to placement with the treatment team;

(ii) the client's current substance use counselor, if applicable;

(iii) a lead member of the client's individualized education program team or school-based mental health provider, if applicable;

(iv) a representative from the client's health care home or primary care clinic, as needed to ensure integration of medical and behavioral health care;

(v) the client's probation officer or other juvenile justice representative, if applicable; and

(vi) the client's current vocational or employment counselor, if applicable.

(d) The treatment supervisor shall be an active member of the treatment team and shall function as a practicing clinician at least on a part-time basis. The treatment team shall meet with the treatment supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting must include client-specific case reviews and general treatment discussions among team members. Client-specific case reviews and planning must be documented in the individual client's treatment record.

(e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment team position.

(f) The treatment team shall serve no more than 80 clients at any one time. Should local demand exceed the team's capacity, an additional team must be established rather than exceed this limit.

(g) Nonclinical staff shall have prompt access in person or by telephone to a mental health practitioner, clinical trainee, or mental health professional. The provider shall have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of clients.

(h) The intensive nonresidential rehabilitative mental health services provider shall participate in evaluation of the assertive community treatment for youth (Youth ACT) model as conducted by the commissioner, including the collection and reporting of data and the reporting of performance measures as specified by contract with the commissioner.

(i) A regional treatment team may serve multiple counties.

EFFECTIVE DATE. The amendment made to paragraph (c), clause (1), item (ii), of this section is effective July 1, 2027, or upon federal approval, whichever is later.

Sec. 21. Minnesota Statutes 2025 Supplement, 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, crisis stabilization provided in a community setting, or crisis assessment as defined in section 256B.0624, subdivision 2.

Sec. 22. **DIRECTION TO COMMISSIONER; CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC REBASING.**

Notwithstanding Minnesota Statutes, section 256B.0625, subdivision 5m, paragraph (c), clause (4), for certified community behavioral health clinics certified on or after January 1, 2021, and before January 1, 2022, the commissioner of human services must rebase rates for purposes of Minnesota Statutes, section 256B.0625, subdivision 5m, paragraph (c), clause (4), for services provided on or after January 1, 2026.

ARTICLE 5
DEPARTMENT OF HUMAN SERVICES HOUSING AND SUPPORT SERVICES

Section 1. Minnesota Statutes 2024, section 245.991, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities.** Grantees must provide homeless outreach and case management services. Projects may provide clinical assessment, habilitation and rehabilitation services, community mental health services, substance use disorder treatment, housing transition and sustaining services, or direct assistance funding. Services must be provided to individuals with a serious mental illness, substance use disorder, or ~~with a~~ co-occurring substance use disorder~~,~~ and who are homeless or at imminent risk of homelessness. Individuals receiving homeless outreach services may be presumed eligible until a serious mental illness can be verified.

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

Sec. 2. Minnesota Statutes 2024, section 245.992, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The commissioner of human services must establish a housing with support for adults with serious mental illness program to prevent or end homelessness for people with serious mental illness, substance use disorder, or co-occurring substance use disorder; to increase the availability of housing with support~~,~~; and to ensure

the commissioner may achieve the goals of the housing mission statement in section 245.461, subdivision 4.

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

Sec. 3. Minnesota Statutes 2024, section 245.992, subdivision 2, is amended to read:

Subd. 2. **Eligible beneficiaries.** Program activities must be provided to people with a serious mental illness, substance use disorder, or ~~with a~~ co-occurring substance use disorder, who meet homeless criteria determined by the commissioner.

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

Sec. 4. Minnesota Statutes 2024, section 256D.05, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Each assistance unit with income and resources less than the standard of assistance established by the commissioner and with a member who is a resident of the state ~~shall~~ must be eligible for and entitled to general assistance if the assistance unit is:

(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 45 days and which prevents the person from obtaining or retaining employment;

(2) a person whose presence in the home on a substantially continuous basis is required because of the professionally certified illness, injury, incapacity, or the age of another member of the household;

(3) a person who has been placed in, and is residing in, a licensed or certified facility for purposes of physical or mental health or rehabilitation, or in an approved substance use disorder domiciliary facility, if the placement is based on illness or incapacity and is according to a plan developed or approved by the county agency through its director or designated representative;

(4) a person not described in clause (1) or (3) who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as developmentally disabled or mentally ill, and that condition prevents the person from obtaining or retaining employment;

(5) a person who has an application pending for, or is appealing termination of benefits from, the Social Security disability program or the program of Supplemental Security Income for the aged, blind, and disabled, provided the person has a professionally certified permanent

or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;

(6) a person who is unable to obtain or retain employment because advanced age significantly affects the person's ability to seek or engage in substantial work;

(7) a person who has been assessed by a vocational specialist and, in consultation with the county agency, has been determined to be unemployable for purposes of this clause; a person is considered employable if there exist positions of employment in the local labor market, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually. The county agency must provide notice to the person not later than 30 days before annual eligibility under this item ends, informing the person of the date annual eligibility will end and the need for vocational assessment if the person wishes to continue eligibility under this clause. For purposes of establishing eligibility under this clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;

(8) a person who is determined by the county agency, according to permanent rules adopted by the commissioner, to have a condition that qualifies under Minnesota's special education rules as a specific learning disability, provided that a rehabilitation plan for the person is developed or approved by the county agency, and the person is following the plan;

(9) a child under the age of 18 who is not living with a parent, stepparent, or legal custodian, and only if: the child is legally emancipated or living with an adult with the consent of an agency acting as a legal custodian; the child is at least 16 years of age and the general assistance grant is approved by the director of the county agency or a designated representative as a component of a social services case plan for the child; or the child is living with an adult with the consent of the child's legal custodian and the county agency. For purposes of this clause, "legally emancipated" means a person under the age of 18 years who: (i) has been married; (ii) is on active duty in the uniformed services of the United States; (iii) has been emancipated by a court of competent jurisdiction; or (iv) is otherwise considered emancipated under Minnesota law, and for whom county social services has not determined that a social services case plan is necessary, for reasons other than the child has failed or refuses to cooperate with the county agency in developing the plan;

(10) a person who is eligible for displaced homemaker services, programs, or assistance under section 116L.96, but only if that person is enrolled as a full-time student;

(11) a person who is involved with protective or court-ordered services that prevent the applicant or recipient from working at least four hours per day;

(12) a person over age 18 whose primary language is not English and who is attending high school at least half time; or

(13) a person whose alcohol and drug addiction is a material factor that contributes to the person's disability~~; applicants who assert this clause as a basis for eligibility must be assessed by the county agency to determine if they are amenable to treatment; if the applicant is determined to be not amenable to treatment, but is otherwise eligible for benefits, then general assistance must be paid in vendor form, for the individual's shelter costs up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a; if the applicant is determined to be amenable to treatment, then in order to receive benefits, the applicant must be in a treatment program or on a waiting list and the benefits must be paid in vendor form, for the individual's shelter costs, up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a~~.

(b) As a condition of eligibility under paragraph (a), clauses (1), (3), (4), (7), and (8), the recipient must complete an interim assistance agreement and must apply for other maintenance benefits as specified in section 256D.06, subdivision 5, and must comply with efforts to determine the recipient's eligibility for those other maintenance benefits.

(c) The burden of providing documentation for a county agency to use to verify eligibility for general assistance or for exemption from the Supplemental Nutrition Assistance Program (SNAP) employment and training program is upon the applicant or recipient. The county agency ~~shall~~ must use documents already in its possession to verify eligibility, and ~~shall~~ must help the applicant or recipient obtain other existing verification necessary to determine eligibility which the applicant or recipient does not have and is unable to obtain.

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

Sec. 5. Minnesota Statutes 2024, section 256D.06, subdivision 2, is amended to read:

Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a grant of emergency general assistance ~~shall~~ must, to the extent funds are available, be made to an eligible single adult, married couple, or family for an emergency need where the recipient requests temporary assistance not exceeding 30 days if an emergency situation appears to exist under written criteria adopted by the county agency and provided to the commissioner annually. If an applicant or recipient relates facts to the county agency which may be sufficient to constitute an emergency situation, the county agency ~~shall~~ must, to the extent funds are available, advise the person of the procedure for applying for assistance according to this subdivision.

(b) The applicant must be ineligible for assistance under chapter 142G, must have annual net income no greater than 200 percent of the federal poverty guidelines for the previous calendar year, and may receive an emergency assistance grant not more than once in any 12-month period.

(c) Funding for an emergency general assistance program is limited to the appropriation. Each fiscal year, the commissioner ~~shall~~ must allocate to counties the money appropriated for emergency general assistance grants based on each county agency's average share of state's emergency general expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. No county shall be allocated less than $1,000 for a fiscal year.

(d) Any emergency general assistance expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

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

Sec. 6. Minnesota Statutes 2024, section 256D.54, subdivision 1, is amended to read:

Subdivision 1. **Potential eligibility.** An applicant or recipient who is otherwise eligible for supplemental aid and who is potentially eligible for maintenance benefits from any other source ~~shall~~ must (1) apply for those benefits within ~~30~~ 90 days of the county's determination of potential eligibility for those benefits; and (2) execute an interim assistance authorization agreement on a form as directed by the commissioner.

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

Sec. 7. Minnesota Statutes 2024, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers of housing support must be in writing on a form developed and approved by the commissioner and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which housing support is provided under this agreement; the per diem and monthly rates that are to be paid from housing support funds for each eligible resident at each location; the number of beds at each location which are subject to the agreement; whether the license holder is a not-for-profit corporation under

section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

(b) Providers are required to verify the following minimum requirements in the agreement:

(1) current license or registration, including authorization if managing or monitoring medications;

(2) all staff who have direct contact with recipients meet the staff qualifications;

(3) the provision of housing support;

(4) the provision of supplementary services, if applicable;

(5) reports of adverse events, including recipient death or serious injury;

(6) submission of residency requirements that could result in recipient eviction; and

(7) confirmation that the provider will not limit or restrict the number of hours an applicant or recipient chooses to be employed, as specified in subdivision 5.

(c) Agreements may be terminated with or without cause by the commissioner, the agency, or the provider with two calendar months prior notice. The commissioner may immediately terminate an agreement under subdivision 2d.

(d) Agencies must develop a process by which the agency seeks, reviews, and approves housing support agreements. Agencies must report the processes and results to the commissioner in a format determined by the commissioner and must make the processes available to prospective housing support providers. For the purposes of this paragraph, "results" includes the number of housing support agreements that are approved and denied, and if denied, the reason for the denial.

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

Sec. 8. **REPEALER.**

Minnesota Statutes 2024, section 256D.09, subdivisions 2a and 2b, are repealed.

ARTICLE 6

DEPARTMENT OF HUMAN SERVICES OFFICE OF THE INSPECTOR GENERAL

Section 1. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, ~~shall~~ must pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$250
greater than $10,000 but less than or equal to $25,000	$375
greater than $25,000 but less than or equal to $50,000	$500
greater than $50,000 but less than or equal to $100,000	$625
greater than $100,000 but less than or equal to $150,000	$750
greater than $150,000 but less than or equal to $200,000	$1,000
greater than $200,000 but less than or equal to $250,000	$1,250
greater than $250,000 but less than or equal to $300,000	$1,500
greater than $300,000 but less than or equal to $350,000	$1,750
greater than $350,000 but less than or equal to $400,000	$2,000
greater than $400,000 but less than or equal to $450,000	$2,250
greater than $450,000 but less than or equal to $500,000	$2,500
greater than $500,000 but less than or equal to $600,000	$2,850
greater than $600,000 but less than or equal to $700,000	$3,200
greater than $700,000 but less than or equal to $800,000	$3,600

greater than $800,000 but less than or equal to $900,000	$3,900
greater than $900,000 but less than or equal to $1,000,000	$4,250
greater than $1,000,000 but less than or equal to $1,250,000	$4,550
greater than $1,250,000 but less than or equal to $1,500,000	$4,900
greater than $1,500,000 but less than or equal to $1,750,000	$5,200
greater than $1,750,000 but less than or equal to $2,000,000	$5,500
greater than $2,000,000 but less than or equal to $2,500,000	$5,900
greater than $2,500,000 but less than or equal to $3,000,000	$6,200
greater than $3,000,000 but less than or equal to $3,500,000	$6,500
greater than $3,500,000 but less than or equal to $4,000,000	$7,200
greater than $4,000,000 but less than or equal to $4,500,000	$7,800
greater than $4,500,000 but less than or equal to $5,000,000	$9,000
greater than $5,000,000 but less than or equal to $7,500,000	$10,000
greater than $7,500,000 but less than or equal to $10,000,000	$14,000
greater than $10,000,000 but less than or equal to $12,500,000	$18,000
greater than $12,500,000 but less than or equal to $15,000,000	$25,000
greater than $15,000,000 but less than or equal to $17,500,000	$28,000
greater than $17,500,000 but less than or equal to $20,000,000	$32,000
greater than $20,000,000 but less than or equal to $25,000,000	$36,000
greater than $25,000,000 but less than or equal to $30,000,000	$45,000
greater than $30,000,000 but less than or equal to $35,000,000	$55,000
greater than $35,000,000	$75,000

(2) If requested, the license holder ~~shall~~ must provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee ~~shall~~ must be subject to a civil penalty in the amount of double the fee the provider should have paid.

(b) A substance use disorder treatment program licensed under chapter 245G, to provide substance use disorder treatment ~~shall~~ must pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, or a withdrawal management program licensed under chapter 245F ~~shall~~ must pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 or more persons	$5,000

A detoxification program that also operates a withdrawal management program at the same location ~~shall~~ must only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200

75 to 99 persons	$1,300
100 or more persons	$1,400

(e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness ~~shall~~ must pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 or more persons	$20,000

(f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities ~~shall~~ must pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(g) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, ~~shall~~ must pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(h) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, ~~shall~~ must pay an annual nonrefundable license fee of $20,000.

(i) A mental health clinic certified under section 245I.20 ~~shall~~ must pay an annual nonrefundable certification fee of $1,550. If the mental health clinic provides services at a

primary location with satellite facilities, the satellite facilities ~~shall~~ must be certified with the primary location without an additional charge.

(j) If a program subject to annual fees under paragraph (b) provides services at a primary location with satellite facilities, the satellite facilities must be licensed with the primary location and must be subject to an additional $500 annual nonrefundable license fee per satellite facility.

Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.142, subdivision 3, is amended to read:

Subd. 3. **Provisional license.** (a) Beginning January 1, 2026, the commissioner ~~shall~~ must begin issuing provisional licenses to agencies enrolled under chapter 256B to provide EIDBI services.

(b) Agencies enrolled before July 1, 2025, have until May 31, 2026, to submit an application for provisional licensure on the forms and in the manner prescribed by the commissioner.

(c) Beginning June 1, 2026, an agency must not operate if it has not submitted an application for provisional licensure under this section. The commissioner shall disenroll an agency from providing EIDBI services under chapter 256B if the agency fails to submit an application for provisional licensure by May 31, 2026.

(d) The commissioner must determine whether a provisional license applicant complies with all applicable rules and laws and either issue a provisional license to the applicant or deny the application by December 31, 2026.

(e) A provisional license is effective until comprehensive EIDBI agency licensure standards are in effect unless the provisional license is suspended or revoked.

(f) Initial provisional license applications are subject to the application fee under section 245A.10, subdivision 3.

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

Sec. 3. Minnesota Statutes 2025 Supplement, section 245A.242, subdivision 2, is amended to read:

Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency treatment of opioid overdose ~~and~~. For administration via intramuscular injection, a license

holder must have a written standing order protocol by a physician who is licensed under chapter 147, advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of intramuscular injection opiate antagonists on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both, before the staff has direct contact, as defined in section 245C.02, subdivision 11, with a person served by the program.

(b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

(1) emergency opiate antagonist medications are not required to be stored in a locked area and staff and adult clients may carry this medication on them and store it in an unlocked location;

(2) staff persons who only administer emergency opiate antagonist medications only require the training required by paragraph (a), which any knowledgeable trainer may provide. The trainer is not required to be a registered nurse or part of an accredited educational institution; and

(3) nonresidential substance use disorder treatment programs that do not administer client medications beyond emergency opiate antagonist medications are not required to have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and must instead describe the program's procedures for administering opiate antagonist medications in the license holder's description of health care services under section 245G.08, subdivision 1.

Sec. 4. Minnesota Statutes 2024, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the website, email, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice in the community;

(14) personal privacy, including the right to use the lock on the person's bedroom or unit door;

(15) engage in chosen activities; and

(16) access to the person's personal possessions at any time, including financial resources.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;

(5) have access to three nutritionally balanced meals and nutritious snacks between meals each day;

(6) have freedom and support to access food and potable water at any time;

(7) have the freedom to furnish and decorate the person's bedroom or living unit;

(8) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(9) a setting that is free from hazards that threaten the person's health or safety; and

(10) a setting that meets the definition of a dwelling unit within a residential occupancy as defined in the State Fire Code.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph (b), clauses (1) to (7), is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's support plan or support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

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

Sec. 5. Minnesota Statutes 2024, section 245D.10, subdivision 4, is amended to read:

Subd. 4. **Availability of current written policies and procedures.** (a) The license holder must review and update, as needed, the written policies and procedures required under this chapter.

(b)(1) The license holder must inform the person, the person's legal representative, and case manager of the policies and procedures affecting a person's rights under section 245D.04, and provide copies of those policies and procedures, within five working days of service initiation.

(2) If a license holder only provides basic services and supports, this includes the:

(i) grievance policy and procedure required under subdivision 2; ~~and~~

(ii) service suspension and termination policy and procedure required under subdivision 3.~~;~~ ; and

(iii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 9, or successor provisions.

(3) For all other license holders this includes the:

(i) policies and procedures in clause (2); and

~~(ii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 9, or successor provisions; and~~

~~(iii)~~ (ii) data privacy requirements under section 245D.11, subdivision 3.

(c) The license holder must provide a written notice to all persons or their legal representatives and case managers at least 30 days before implementing any procedural revisions to policies affecting a person's service-related or protection-related rights under section 245D.04 and maltreatment reporting policies and procedures. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the reasonable cause for not providing the notice at least 30 days before implementing the revisions.

(d) Before implementing revisions to required policies and procedures, the license holder must inform all employees of the revisions and provide training on implementation of the revised policies and procedures.

(e) The license holder must annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under this chapter, other than those in paragraph (c). Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures.

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

Sec. 6. Minnesota Statutes 2025 Supplement, 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, psychiatric residential treatment facility, 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. 7. Minnesota Statutes 2025 Supplement, 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~~ must 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. A person mandated to report child maltreatment occurring within a federally certified psychiatric residential treatment facility must report the information to the Department of Health.

Sec. 8. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended to read:

Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency responsible for investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D, except federally certified psychiatric residential treatment facilities.

(c) The Department of Health is the agency responsible for screening and investigating allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H, and federally certified as a psychiatric residential treatment facility.

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under sections 245A.142 and 256B.0949.

(f) A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

(g) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in facilities or programs not listed in paragraph (a) that are licensed or certified under chapters 142B and 142C.

Sec. 9. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, federally certified psychiatric residential treatment facilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services, except federally certified psychiatric residential treatment facilities. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including but not limited to reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

ARTICLE 7
CHILDREN, YOUTH, AND FAMILIES

Section 1. Minnesota Statutes 2024, section 142A.43, is amended to read:

142A.43 ~~GRANTS-IN-AID~~ GRANTS TO YOUTH INTERVENTION PROGRAMS.

Subdivision 1. **Grants.** (a) The commissioner ~~may~~ must make grants to nonprofit agencies administering youth intervention programs in communities where the programs are or may be established. Grants under this section are limited to available appropriations. No grant may exceed $75,000.

(b) "Youth intervention program" means a nonresidential community-based program providing advocacy, education, counseling, mentoring, and referral services to youth and their families experiencing personal, familial, school, legal, or chemical problems with the goal of resolving the present problems and preventing the occurrence of the problems in the future. The intent of the youth intervention program is to provide an ongoing stable funding source to community-based early intervention programs for youth. Program design may be different for the grantees depending on youth service needs of the communities being served.

(c) A grant under this section is contingent upon the agency obtaining local matching money equal to the amount of the grant from the community in which the youth intervention program is established. The matching requirement is intended to leverage the investment of state and community money in supporting the efforts of the grantees to provide early intervention services to youth and their families.

Subd. 2. **Applications.** Applications for a ~~grant-in-aid shall~~ grant must be ~~made~~ submitted by the administering agency to the commissioner. The commissioner must provide the application form, procedures for submitting application forms, criteria for review of the application, and a description of the kinds of contributions in addition to cash that qualify as local matching money.

~~The grant-in-aid is contingent upon the agency having obtained from the community in which the youth intervention program is established local matching money equal to the amount of the grant that is sought. The matching requirement is intended to leverage the investment of state and community dollars in supporting the efforts of the grantees to provide early intervention services to youth and their families.~~

~~The commissioner shall provide the application form, procedures for making application form, criteria for review of the application, and kinds of contributions in addition to cash that qualify as local matching money. No grant to any agency may exceed $75,000.~~

Subd. 3. ~~**Grant allocation formula**~~ **Youth Intervention Programs Association grant.** Up to ~~five~~ six percent of the ~~appropriations to the grants-in-aid to the youth intervention program may~~ appropriation for grants under this section must be used for a grant to the Minnesota Youth Intervention Programs Association for ~~expenses in~~ providing collaboration, program development, professional development training, technical assistance, and tracking, ~~and~~ analyzing, and reporting outcome data for the community-based grantees of the program. The Minnesota Youth Intervention Programs Association is not required to meet the ~~match obligation~~ matching requirement under subdivision ~~2~~ 1, paragraph (c).

Subd. 4. **Report.** On or before March 31 of each year, the Minnesota Youth Intervention Programs Association shall report to the chairs and ranking minority members of the committees and divisions with jurisdiction over ~~public safety policy and finance~~ children and youth on the implementation, use, and administration of the grant program ~~created~~ under this section. The report shall include information sent by agencies administering youth intervention programs to the Minnesota Youth Intervention Programs Association ~~and the Office of Justice Programs~~. At a minimum, the report must identify:

(1) the grant recipients;

(2) the geographic location of the grant recipients;

(3) the total number of individuals served by all grant recipients, disaggregated by race, ethnicity, and gender;

(4) the total number of individuals served by all grant recipients who successfully completed programming, disaggregated by age, race, ethnicity, and gender;

(5) the total amount of money awarded in grants and the total amount remaining to be awarded from each appropriation;

(6) the amount of money granted to each recipient;

(7) ~~grantee~~ grant recipient workplan objectives;

(8) how the grant was used based on ~~grantee~~ grant recipient quarterly narrative reports and financial reports; and

(9) summarized relevant youth intervention program outcome survey data measuring the developmental assets of participants, based on Search Institute's Developmental Assets Framework.

~~Subd. 5. **Administrative costs.** The commissioner may use up to ten percent of the biennial appropriation for grants-in-aid to the youth intervention program to pay costs incurred by the department in administering the youth intervention program.~~

Sec. 2. Minnesota Statutes 2024, section 142B.10, subdivision 18, is amended to read:

Subd. 18. **Adoption agency; additional requirements.** In addition to the other requirements of this section, an individual or organization applying for a license to place children for adoption must:

(1) incorporate as a nonprofit corporation under chapter 317A or a nonprofit limited liability company under chapter 322C;

(2) file with the application for licensure a copy of the disclosure form required under section 259.37, subdivision 2;

(3) provide evidence that a bond has been obtained and will be continuously maintained throughout the entire operating period of the agency, to cover the cost of transfer of records to and storage of records by the agency which has agreed, according to rule established by the commissioner, to receive the applicant agency's records if the applicant agency voluntarily or involuntarily ceases operation and fails to provide for proper transfer of the records. The bond must be made in favor of the agency which has agreed to receive the records; and

(4) submit a financial review completed by an accountant to the commissioner each year the license is renewed as required under section 142B.05, subdivision 1.

Sec. 3. Minnesota Statutes 2024, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care background study subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. Except as provided in section 245C.05, subdivision 5a, a child care background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.

(c) ~~At reauthorization or~~ When a new background study is needed under section 142E.16, subdivision 2, for a legal nonlicensed child care provider authorized under chapter 142E:

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 142E and:

(1) except as provided in section 245C.05, subdivision 5a, the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraph (b), for background studies conducted by the commissioner for all family adult day services, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 142E;

(2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and

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

(h) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

(i) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(j) For purposes of this section, a physician licensed under chapter 147, advanced practice registered nurse licensed under chapter 148, or physician assistant licensed under chapter 147A is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's, advanced practice registered nurse's, or physician assistant's background study results.

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

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

(m) Before and after school programs authorized under chapter 142E, are exempt from the background study requirements under section 123B.03, for an employee for whom a background study under this chapter has been completed.

Sec. 4. Minnesota Statutes 2024, section 256B.055, subdivision 17, is amended to read:

Subd. 17. **Adults who were in foster care at the age of 18, 19, or 20.** (a) Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18, 19, or 20 years of age or receiving foster care benefits past 18 years of age under section 260C.451, and who was enrolled in medical assistance under the state plan or a waiver of the plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

(b) Medical assistance may be paid for a person under 26 years of age who was in foster care and enrolled in any state's Medicaid program as provided by Public Law 115-271, section 1002.

(c) The commissioner ~~shall~~ must seek federal waiver approval under United States Code, title 42, section 1315, to include youth who were in a state's foster care program and who turned age 18 prior to January 1, 2023, without regard to potential eligibility under a Medicaid mandatory group.

Sec. 5. Minnesota Statutes 2024, section 259.83, subdivision 1, is amended to read:

Subdivision 1. **Services provided.** (a) Agencies ~~shall~~ must provide assistance and counseling services upon receiving a request for current information from adoptive parents, birth parents, adopted persons aged 18 years of age and older, or adult siblings of adopted persons. The agency ~~shall~~ must contact the other adult persons or the adoptive parents of a minor child in a personal and confidential manner to determine whether there is a desire to receive or share information or to have contact. If there is such a desire, the agency ~~shall~~ must provide the services requested. The agency ~~shall~~ must complete the search request within six months of the request being made. If the agency is unable to complete the search

request within the specified time frame, the agency ~~shall~~ must inform the requester of the status of the request and include a reasonable estimate of when the request can be completed.

(b) Upon a request for assistance or services from an adoptive parent of a minor child, birth parent, or an adopted person 18 years of age or older, the agency must inform the person:

(1) about the right of an adopted person to request and obtain a copy of the adopted person's original birth record at the age and circumstances specified in section ~~144.2253~~ 144.2252; and

(2) about the right of the birth parent named on the adopted person's original birth record to file a contact preference form with the state registrar pursuant to section 144.2253.

When making or supervising an adoptive placement, the agency must provide in writing to the birth parents listed on the original birth record the information required under this paragraph and section 259.37, subdivision 2, clause (7).

Sec. 6. Minnesota Statutes 2024, section 260.67, subdivision 1, is amended to read:

Subdivision 1. **Preference for permanency placement with a relative.** Consistent with section 260C.513, if an African American or disproportionately represented child cannot be returned to the child's parent, permanency placement with a relative is preferred. The court ~~shall~~ must consider the requirements of and responsibilities under section 260.012, paragraph (a), and, if possible and if requirements under section 260C.515, subdivision 4, are met, transfer permanent legal and physical custody of the child to:

(1) a noncustodial parent under section 260C.515, subdivision 4, if the child cannot return to the care of the parent or custodian from whom the child was removed or who had legal custody at the time that the child was placed in foster care; or

(2) a willing and able relative, according to the requirements of section 260C.515, subdivision 4. When the responsible social services agency is the petitioner, prior to the court ordering a transfer of permanent legal and physical custody to a relative, the responsible social services agency must inform the relative of Northstar kinship assistance benefits and eligibility requirements and of the relative's ability to apply for benefits on behalf of the child under ~~chapter 256N~~ sections 142A.60 to 142A.612.

Sec. 7. Minnesota Statutes 2024, section 260C.190, subdivision 1, is amended to read:

Subdivision 1. **Placement.** (a) An agency with legal responsibility for a child under section 260C.178, subdivision 1, paragraph (c), or legal custody of a child under section

260C.201, subdivision 1, paragraph (a), clause ~~(3)~~ (2), may colocate a child with a parent who is receiving services in a licensed residential family-based substance use disorder treatment program for up to 12 months.

(b) During the child's placement under paragraph (a), the agency: (1) may visit the child as the agency deems necessary and appropriate; (2) ~~shall~~ must continue to have access to information under section 260C.208; and (3) ~~shall~~ must continue to provide appropriate services to both the parent and the child.

(c) The agency may terminate the child's placement under paragraph (a) to protect the child's health, safety, or welfare and may remove the child to foster care without a prior court order or authorization.

Sec. 8. Minnesota Statutes 2024, section 260C.212, subdivision 4a, is amended to read:

Subd. 4a. **Monthly caseworker visits.** (a) Every child in foster care or on a trial home visit ~~shall~~ must be visited by the child's caseworker or another person who has responsibility for visitation of the child on a monthly basis, with the majority of visits occurring in the child's residence. The responsible social services agency may designate another person responsible for monthly case visits. For the purposes of this section, the following definitions apply:

(1) "visit" is defined as a face-to-face contact between a child and the child's caseworker. For a youth 18 years of age or older, a visit may be conducted via video conference with the youth's informed consent;

(2) "visited on a monthly basis" is defined as at least one visit per calendar month;

(3) "the child's caseworker" is defined as the person who has responsibility for managing the child's foster care placement case as assigned by the responsible social services agency;

(4) "another person" means the professional staff whom the responsible social services agency has assigned in the out-of-home placement plan or case plan. Another person must be professionally trained to assess the child's safety, permanency, well-being, and case progress. The agency may not designate the guardian ad litem, the child foster care provider, residential facility staff, or a qualified individual as defined in section 260C.007, subdivision26b, as another person; and

(5) "the child's residence" is defined as the home where the child is residing, and can include the foster home, child care institution, or the home from which the child was removed if the child is on a trial home visit.

(b) Caseworker visits ~~shall~~ must be of sufficient substance and duration to address issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the child, including whether the child is enrolled and attending school as required by law.

(c) Every effort ~~shall~~ must be made by the responsible social services agency and professional staff to have the monthly visit with the child outside the presence of the child's parents, foster parents, or facility staff. There may be situations related to the child's needs when a caseworker visit cannot occur with the child alone. The reason the caseworker visit occurred in the presence of others must be documented in the case record and may include:

(1) that the child exhibits intense emotion or behavior indicating that visiting without the presence of the parent, foster parent, or facility staff would be traumatic for the child;

(2) that despite a caseworker's efforts, the child declines to visit with the caseworker outside the presence of the parent, foster parent, or facility staff; and

(3) that the child has a specific developmental delay, physical limitation, incapacity, medical device, or significant medical need, such that the parent, foster parent, or facility staff is required to be present with the child during the visit.

Sec. 9. Minnesota Statutes 2024, section 260C.451, subdivision 2, is amended to read:

Subd. 2. **Independent living plan.** ~~Upon the request of~~ (a) For any child in foster care who is 14 years of age or older, the responsible social services agency must, in conjunction with the child and other appropriate parties, develop and update the child's independent living plan required under section 260C.212, subdivision 1, paragraph (c), clause (12).

(b) For any child in foster care immediately prior to the child's 18th birthday ~~and who is in foster care at the time of the request~~, the responsible social services agency ~~shall~~ must, in conjunction with the child and other appropriate parties, update the child's independent living plan required under section 260C.212, subdivision 1, paragraph (c), clause (12), related to the child's employment, vocational, educational, social, or maturational needs and submit it to the court as part of the required review under section 260C.202, subdivision 3. The agency ~~shall~~ must provide continued services and foster care for the child including those services that are necessary to implement the independent living plan.

Sec. 10. Minnesota Statutes 2024, section 260C.451, subdivision 3, is amended to read:

Subd. 3. **Eligibility to continue in foster care.** A child in foster care immediately prior to the child's 18th birthday may continue in foster care past age 18 unless:

(1) the child can safely return home; or

(2) ~~the child is in placement pursuant to the agency's duties under section 256B.092 and Minnesota Rules, parts 9525.0004 to 9525.0016, to meet the child's needs due to a developmental disability or related condition, and the child will be served as an adult under section 256B.092 and Minnesota Rules, parts 9525.0004 to 9525.0016; or~~

~~(3)~~ the child can be adopted or have permanent legal and physical custody transferred to a relative prior to the child's 18th birthday.

Sec. 11. Minnesota Statutes 2024, section 260C.451, subdivision 3a, is amended to read:

Subd. 3a. **Eligibility criteria.** The child must meet at least one of the following conditions to be considered eligible to continue in or return to foster care and remain there to age 21. The child must be:

(1) completing secondary education or a program leading to an equivalent credential, including transition programs through a public or private school;

(2) enrolled in an institution that provides postsecondary or vocational education;

(3) participating in a program or activity designed to promote or remove barriers to employment;

(4) employed for at least 80 hours per month, including receiving benefits under chapter 268B; or

(5) incapable of doing any of the activities described in clauses (1) to (4) due to a medical condition.

Sec. 12. Minnesota Statutes 2025 Supplement, section 260C.451, subdivision 8, is amended to read:

Subd. 8. **Notice of termination of foster care.** When a child in foster care between the ages of 18 and 21 ceases to meet one of the eligibility criteria of subdivision 3a, the responsible social services agency ~~shall~~ must give the child written notice that foster care will terminate 30 days from the date the notice is sent. The agency must send a copy of the written notice to the commissioner of children, youth, and families. The child or the child's guardian ad litem may file a motion asking the court to review the agency's determination within 15 days of receiving the notice. The child ~~shall~~ must not be discharged from foster care until the motion is heard. The agency ~~shall work~~ must engage with the child to develop a transition ~~out of foster care~~ plan as required under section 260C.452, subdivision 4,

paragraph (d), that addresses the goals listed in section 260C.203, subdivision 4, clause (2). The written notice of termination of benefits ~~shall~~ must be on a form prescribed by the commissioner and ~~shall~~ must also give notice of the right to have the agency's determination reviewed by the court in the proceeding where the court conducts the reviews required under section 260C.203, 260C.317, or 260C.515, subdivision 5 or 6. A copy of the termination notice ~~shall~~ must be sent to the child and the child's attorney, if any, the foster care provider, the child's guardian ad litem, the commissioner of children, youth, and families, and the court. The agency is not responsible for paying foster care benefits for any period of time after the child actually leaves foster care.

Sec. 13. Minnesota Statutes 2024, section 260E.02, subdivision 1, is amended to read:

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

Sec. 14. Minnesota Statutes 2024, section 260E.02, subdivision 2, is amended to read:

Subd. 2. **Duties of team.** A multidisciplinary child protection team may provide public and professional education, develop resources for prevention, intervention, and treatment, and provide case consultation to the local welfare agency or other interested community-based agencies. The community-based agencies may request case consultation from the multidisciplinary child protection team regarding a child or family for whom the community-based agency is providing services. As used in this section, "case consultation" means a case review process in which recommendations are made concerning services to be provided to the identified children and family. Case consultation may be performed by

a committee or subcommittee of members representing human services or children's services, including mental health and substance use disorder providers; law enforcement, including probation and parole; Tribal law enforcement; the county attorney; a children's advocacy center; health care; education; community-based agencies and other necessary agencies; and persons directly involved in an individual case as designated by other members performing case consultation.

Sec. 15. Minnesota Statutes 2024, section 260E.02, is amended by adding a subdivision to read:

Subd. 3a. **Missing and murdered Indigenous relatives.** A multidisciplinary child protection team may assist the local welfare agency, the local law enforcement agency, or an appropriate private organization in developing a responsive program for youth who are at risk of going missing or being murdered, or whose family member has been identified as a missing and murdered Indigenous relative. At least one representative of a nonprofit agency serving youth who are at risk of going missing or being murdered, or an agency serving families with missing and murdered Indigenous relatives, must be appointed to and serve on the multidisciplinary child protection team in addition to the standing members of the team.

Sec. 16. Laws 2025, First Special Session chapter 3, article 22, section 20, subdivision 2, is amended to read:

Subd. 2. **Youth Intervention Programs Association Grant**

Notwithstanding the percentage requirement under Minnesota Statutes, section 142A.43, subdivision 3, $355,000 in fiscal year 2026 ~~and $355,000 in fiscal year 2027 are~~ is for a grant to the Minnesota Youth Intervention Programs Association for collaboration, program development, professional development training, technical assistance, tracking, and analyzing and reporting outcome data for the community-based grantees of the program.

ARTICLE 8
MNSURE POLICY

Section 1. Minnesota Statutes 2024, section 62V.05, subdivision 7, is amended to read:

Subd. 7. **Agreements; consultation.** (a) The board shall:

(1) establish and maintain an agreement with the commissioner of human services for cost allocation and services regarding eligibility determinations and enrollment for public health care programs that use a modified adjusted gross income standard to determine program eligibility. The board may establish and maintain an agreement with the commissioner of human services for other services;

(2) establish and maintain an agreement with the commissioners of commerce and health for services regarding enforcement of MNsure certification requirements for health plans and dental plans offered through MNsure. The board may establish and maintain agreements with the commissioners of commerce and health for other services; and

(3) establish interagency agreements to transfer funds to other state agencies for their costs related to implementing and operating MNsure, excluding medical assistance allocatable costs.

(b) The board shall consult with the commissioners of commerce and health regarding the operations of MNsure.

(c) The board shall consult with Indian tribes and organizations regarding the operation of MNsure.

~~(d) Beginning March 15, 2016, and each March 15 thereafter, the board shall submit a report to the chairs and ranking minority members of the committees in the senate and house of representatives with primary jurisdiction over commerce, health, and human services on all the agreements entered into with the chief information officer of the Department of Information Technology Services, or the commissioners of human services, health, or commerce in accordance with this subdivision. The report shall include the agency in which the agreement is with; the time period of the agreement; the purpose of the agreement; and a summary of the terms of the agreement. A copy of the agreement must be submitted to the extent practicable.~~

Sec. 2. Minnesota Statutes 2024, section 62V.13, is amended to read:

62V.13 EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM.

Subdivision 1. **Establishment.** The board, in cooperation with the commissioner of revenue, must establish the easy enrollment health insurance outreach program to:

(1) reduce the number of uninsured Minnesotans and increase access to affordable health insurance coverage;

(2) allow the commissioner of revenue to provide return information, at the request of the taxpayer, to MNsure to provide the taxpayer with information about the taxpayer's potential eligibility for financial assistance and health insurance enrollment options through MNsure;

(3) allow MNsure to ~~estimate taxpayer potential eligibility for financial assistance for health insurance coverage~~ provide general information regarding potential eligibility for health insurance programs and financial assistance available through MNsure; and

(4) allow MNsure to conduct targeted outreach to assist interested taxpayer households in applying for and enrolling in affordable health insurance options through MNsure, including connecting interested taxpayer households with a navigator or broker for free enrollment assistance.

Subd. 2. **Screening for eligibility for insurance assistance.** Upon receipt of ~~and based on~~ return information received from the commissioner of revenue under section 270B.14, subdivision 22, MNsure may ~~make a projected assessment on whether the interested taxpayer's household may qualify for a financial assistance program for health insurance coverage~~ review the information to identify households that may benefit from health coverage through MNsure and provide general information on available coverage and financial assistance programs.

Subd. 3. **Outreach letter and special enrollment period.** (a) MNsure must provide a written letter ~~of the projected assessment under subdivision 2~~ with general information about health insurance coverage and financial assistance available through MNsure to a taxpayer who indicates to the commissioner of revenue that the taxpayer is interested in obtaining information on access to health insurance.

(b) MNsure must allow a special enrollment period for taxpayers who receive the outreach letter in paragraph (a) and are determined eligible to enroll in a qualified health plan through MNsure. The triggering event for the special enrollment period is the day the outreach letter under this subdivision is mailed to the taxpayer. An eligible individual, and their dependents,

have 65 days from the triggering event to select a qualifying health plan and coverage for the qualifying health plan is effective the first day of the month after plan selection.

(c) Taxpayers who have a member of the taxpayer's household currently enrolled in a qualified health plan through MNsure are not eligible for the special enrollment under paragraph (b).

(d) MNsure must provide information to the general public about the easy enrollment health insurance outreach program and the special enrollment period described in this subdivision.

Subd. 4. **Appeals.** (a) ~~Projected~~ Any eligibility ~~assessments for financial assistance under this section are not appealable~~ information provided under this section is not appealable.

(b) Qualification for the special enrollment period under this section is appealable to MNsure under this chapter and Minnesota Rules, chapter 7700.

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

ARTICLE 9
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 62A.01, is amended by adding a subdivision to read:

Subd. 5. **Direct primary care service agreements.** (a) A direct primary care service agreement under section 62Q.20 is not insurance and is not subject to this chapter. Entering into a direct primary care service agreement is not the business of insurance and is not subject to this chapter or chapter 60A.

(b) A health care provider or agent of a health care provider is not required to obtain a certificate of authority or license under this chapter or chapter 60A, 62C, 62D, or 62N to market, sell, or offer to sell a direct primary care service agreement that meets the requirements of section 62Q.20.

Sec. 2. Minnesota Statutes 2024, section 62A.011, subdivision 3, is amended to read:

Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate

offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, including coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance, if the benefits are provided under a separate policy, certificate, or contract for insurance; there is no coordination between the provision of benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide hearing, dental, or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46 or 62S.01;

(10) issued as a supplement to Medicare, as defined in sections 62A.3099 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876, section 1851, et seq.; or section 1860D-1, et seq., of title XVIII of the federal Social Security Act, et seq., as amended;

(11) workers' compensation insurance;

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan;

(13) coverage for on-site medical clinics; ~~or~~

(14) coverage supplemental to the coverage provided under United States Code, title 10, chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)~~.~~; or

(15) coverage provided under a direct primary care service agreement described under section 62Q.20.

Sec. 3. **[62Q.20] DIRECT PRIMARY CARE SERVICE AGREEMENT.**

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

(b) "Direct fee" means a fee charged by a direct primary care practice as consideration for being available to provide and for providing primary care services to a direct patient as specified in the direct agreement.

(c) "Direct patient" means an individual who is party to a direct agreement and is entitled to receive primary care services under the direct agreement from the direct primary care practice.

(d) "Direct primary care practice" or "direct practice" means a primary care provider who furnishes primary care services through a direct agreement.

(e) "Direct primary care service agreement" or "direct agreement" means a written agreement entered into between a direct primary care practice and a direct patient, or the direct patient's legal representative, in which the primary care direct practice charges a direct fee as consideration for being available to provide and for providing direct primary care services to the direct patient.

(f) "Primary care provider" means a physician who is licensed under chapter 147 or an advanced practice registered nurse licensed under chapter 148, who is authorized to engage in independent practice, and who is qualified to provide primary care services. This term includes an individual primary care provider or a group of primary care providers.

(g) "Primary care services" means:

(1) routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of the promotion of health, and the detection and management of disease or injury within the competency and training of the primary care provider;

(2) medical supplies and prescription drugs that are administered or dispensed in the primary care provider's office or clinic; and

(3) laboratory work, including routine blood screening and routine pathology screening performed by a laboratory that is either associated with the direct primary care practice or is not associated with the direct primary care practice but has entered into a contract with the practice to provide laboratory work without charging a fee to the patient for the laboratory work.

Subd. 2. **Direct primary care services agreement requirements.** (a) To be considered a direct primary care service agreement for purposes of this section, the direct agreement must:

(1) be in writing;

(2) be signed by the primary care provider or agent of the primary care practice and the direct patient or the patient's legal representative;

(3) allow either party to terminate the direct agreement upon written notice to the other party according to subdivision 3;

(4) describe the scope of the primary care services that are to be covered under the direct agreement;

(5) specify the fee to be paid on a monthly basis or as specified in the direct agreement; and

(6) specify the duration of the direct agreement.

(b) The direct agreement must clearly state that a direct primary care service agreement: is not considered health insurance and does not meet the requirements of federal law mandating individuals to purchase health insurance and the fees charged in the agreement may not be reimbursed or applied toward a deductible under a health plan offered through a health plan company.

Subd. 3. **Acceptance and discontinuance of patients.** (a) A direct practice may not decline to accept a new patient or discontinue care to an existing patient solely on the basis of the patient's health status. A direct practice may decline to accept a patient if:

(1) the practice has reached its maximum capacity;

(2) the patient's medical condition is such that the practice is unable to provide the level and type of primary care services the patient requires; or

(3) the patient has previously terminated a direct agreement with the direct practice within the preceding year.

(b) A direct patient or the patient's legal representative may terminate a direct agreement for any reason by providing written notice to the direct practice. Termination of the direct agreement is effective the first day of the month following the month the termination notice is provided to the direct practice. A direct practice may subsequently decline to accept the direct patient as a patient if the patient has terminated a previous direct agreement with the direct practice within the preceding year.

(c) A direct practice may terminate a direct agreement for any reason by providing written notice to the direct patient or the direct patient's representative. A direct practice must provide notice of termination at least 30 days prior to the effective date of termination.

(d) A direct practice may discontinue care to a direct patient if the direct practice discontinues operation as a direct primary care practice. Notice must be provided to the direct patient or the patient's legal representative specifying the effective date of termination. Notice must be sufficient to provide the patient with the opportunity to obtain care from another provider.

Subd. 4. **Direct fees.** (a) The direct fee charged must represent the total amount due for all primary care services specified in the direct agreement provided to the direct patient within the specified time period. The direct fee must not vary from patient to patient based on the patient's health status or sex. The direct fee may be paid by the direct patient, by the patient's legal representative, or on the patient's behalf by a third party. The direct fee may be billed at the end of each monthly period or may be paid in advance for a period not to exceed 12 months.

(b) Upon receipt of a written notice of termination of the direct agreement from a direct patient or the patient's legal representative, the direct practice must promptly refund the unearned amount of the direct fees. If the direct practice discontinues care for any reason described under subdivision 3, the direct practice must promptly refund to the direct patient the unearned amount of the direct fees at a prorated amount of the direct fee earned for the current month based on the date the notice for termination was sent to the direct patient or the direct patient's legal representative.

(c) A direct practice shall not increase the monthly fee that has been negotiated with an existing direct patient more frequently than on an annual basis. A direct practice must provide advance notice of at least 60 days to existing patients of any change in the direct fee.

Subd. 5. **Conduct of business.** (a) A direct practice must maintain appropriate accounts regarding payments made and services received by a direct patient and upon request provide any data requested to the direct patient or the patient's legal representative.

(b) A direct practice must not submit a claim for payment to a health plan company for a primary care service provided to a direct patient that is covered by a direct agreement.

(c) No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising related to the business of a direct practice.

(d) No person shall make, issue, or circulate, or cause to be made, issued, or circulated, a misrepresentation of the terms of a direct agreement or the benefits or advantages promised, or use the name or title of a direct agreement misrepresenting the nature of the direct agreement.

Subd. 6. **Other care not prohibited.** A direct primary care practice is not prohibited from providing services to other patients under a separate contract with a health plan company.

Subd. 7. **Enforcement.** A violation of this section shall constitute unprofessional conduct and may be grounds for disciplinary action under chapters 147 and 148.

Sec. 4. Minnesota Statutes 2024, section 142G.18, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) An individual who has been convicted of a felony level drug offense during the previous ten years from the date of application or recertification ~~is subject to the following:~~ may, if otherwise eligible, receive MFIP benefits.

~~(1) Benefits for the entire assistance unit must be paid in vendor form for shelter and utilities during any time the applicant is part of the assistance unit.~~

~~(2) The convicted applicant or participant may be subject to random drug testing. Following any positive test for an illegal controlled substance, the county must provide information about substance use disorder treatment programs to the applicant or participant.~~

(b) Applicants requesting only SNAP benefits or participants receiving only SNAP benefits, who have been convicted of a felony-level drug offense during the previous ten years from the date of application or recertification may, if otherwise eligible, receive SNAP benefits. ~~The convicted applicant or participant may be subject to random drug testing. Following a positive test for an illegal controlled substance, the county must provide information about substance use disorder treatment programs to the applicant or participant.~~

(c) For the purposes of this subdivision, "drug offense" means a conviction that occurred during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, 152.096, or 152.137. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the conviction occurred during the previous ten years from the date of application or recertification and the conviction is for a crime that would be a felony if committed in Minnesota.

~~(d) This subdivision does not apply for convictions or positive test results related to cannabis, marijuana, or tetrahydrocannabinols.~~

Sec. 5. Minnesota Statutes 2024, section 144E.123, subdivision 1, is amended to read:

Subdivision 1. **Collection and maintenance.** A licensee shall collect and provide prehospital care data to the director in a manner prescribed by the director. At a minimum, the data must include the prehospital care data listed in subdivision 6, paragraph (b), and items identified by the director that are part of the National Uniform Emergency Medical Services Data Set. A licensee shall maintain prehospital care data for every response.

Sec. 6. Minnesota Statutes 2024, section 144E.123, is amended by adding a subdivision to read:

Subd. 6. **Reporting to Office of Emergency Medical Services.** (a) For purposes of this subdivision, "municipality" means a town or a statutory or home rule charter city.

(b) A licensee must annually collect the following prehospital care data for all emergency responses provided by the licensee within the boundaries of each municipality in the licensee's primary service area:

(1) total number of emergency ambulance calls;

(2) for each emergency ambulance call:

(i) dispatch reason;

(ii) type of emergency service requested;

(iii) response mode to scene;

(iv) response mode to hospital;

(v) transport destination; and

(vi) patient pay fee schedule;

(3) percent transport disposition; and

(4) mutual aid given and received, disaggregated by municipality.

(c) A licensee must report the prehospital care data collected under paragraph (b) for the previous calendar year to the director.

(d) The director must make prehospital care data collected under paragraph (b) publicly available annually.

Sec. 7. Minnesota Statutes 2024, section 151.01, subdivision 35, is amended to read:

Subd. 35. **Compounding.** "Compounding" means preparing, mixing, assembling, packaging, and labeling a drug for an identified individual patient as a result of a practitioner's prescription drug order. Compounding also includes anticipatory compounding, as defined in this section, and the preparation of drugs in which all bulk drug substances and components are nonprescription substances. Compounding does not include mixing or reconstituting a drug according to the product's labeling or to the manufacturer's directions, provided that such labeling has been approved by the United States Food and Drug Administration (FDA) or the manufacturer is licensed under section 151.252. Compounding does not include the preparation of a drug for the purpose of, or incident to, research, teaching, or chemical analysis, provided that the drug is not prepared for dispensing or administration to patients. All compounding, regardless of the type of product, must be done pursuant to a prescription drug order unless otherwise permitted in this chapter or by the rules of the board. Compounding does not include a minor deviation from such directions with regard to radioactivity, volume, or stability, which is made by or under the supervision of a licensed nuclear pharmacist or a physician, and which is necessary in order to accommodate circumstances not contemplated in the manufacturer's instructions, such as the rate of radioactive decay or geographical distance from the patient. Compounding does not include the use of a flavoring agent to flavor a drug.

Sec. 8. Minnesota Statutes 2024, section 151.01, is amended by adding a subdivision to read:

Subd. 44. **Flavoring agent.** "Flavoring agent" means a therapeutically inert, nonallergenic substance consisting of inactive ingredients that is added to a drug to improve the drug's taste and palatability.

Sec. 9. Minnesota Statutes 2024, section 151.555, subdivision 7, is amended to read:

Subd. 7. **Standards and procedures for inspecting and storing donated drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory.

(c) The central repository and local repositories shall dispose of all drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of accepted donated drugs and supplies that are not dispensed under subdivision 8~~, are subject to a recall under paragraph (e), or are not suitable for donation~~ or are subject to a recall under paragraph (e) shall be maintained by the repository for at least two years. ~~For each drug or supply destroyed,~~ The record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

No other record of destruction is required.

Sec. 10. Laws 2025, First Special Session chapter 3, article 23, section 2, subdivision 12, is amended to read:

Subd. 12. **Board of Pharmacy**

	Appropriations by Fund	
General	937,000	937,000
State Government Special Revenue	6,280,000	6,280,000

Medication Repository Program. $450,000 in fiscal year 2026 and $450,000 in fiscal year 2027 are from the general fund for the medication repository program ~~to purchase prescription drugs~~ under Minnesota Statutes, section 151.555~~, subdivision 6, paragraph (g)~~.

Sec. 11. **REPEALER.**

Minnesota Statutes 2024, sections 62U.10, subdivision 4; 256B.69, subdivision 31a; and 256D.024, subdivision 1, are repealed.

APPENDIX
Article locations for S3295-2

ARTICLE 1	HEALTH-RELATED OCCUPATIONS	Page.Ln 2.10
ARTICLE 2	DEPARTMENT OF HEALTH	Page.Ln 26.1
ARTICLE 3	HUMAN SERVICES HEALTH CARE	Page.Ln 60.26
ARTICLE 4	BEHAVIORAL HEALTH	Page.Ln 66.15
ARTICLE 5	DEPARTMENT OF HUMAN SERVICES HOUSING AND SUPPORT SERVICES	Page.Ln 97.14
ARTICLE 6	DEPARTMENT OF HUMAN SERVICES OFFICE OF THE INSPECTOR GENERAL	Page.Ln 103.1
ARTICLE 7	CHILDREN, YOUTH, AND FAMILIES	Page.Ln 114.26
ARTICLE 8	MNSURE POLICY	Page.Ln 127.1
ARTICLE 9	MISCELLANEOUS	Page.Ln 129.14

13D.08 OPEN MEETING LAW CODED ELSEWHERE.

Subd. 4. **Health Technology Advisory Committee.** Certain meetings of the Health Technology Advisory Committee are governed by section 62J.156.

62D.08 ANNUAL REPORT.

Subd. 7. **Consistent administrative expenses and investment income reporting.** (a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

62D.181 INSOLVENCY; MCHA ALTERNATIVE COVERAGE.

Subdivision 1. **Definition.** "Association" means the Minnesota Comprehensive Health Association created in section 62E.10.

Subd. 2. **Eligible individuals.** An individual is eligible for alternative coverage under this section if:

(1) the individual had individual health coverage through a health maintenance organization or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization or community integrated service network, and the individual has not obtained alternative coverage; or

(2) the individual had group health coverage through a health maintenance organization or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization or community integrated service network, and the individual has not obtained alternative coverage.

Subd. 3. **Application and issuance.** If a health maintenance organization or community integrated service network will be liquidated, individuals eligible for alternative coverage under subdivision 2 may apply to the association to obtain alternative coverage. Upon receiving an application and evidence that the applicant was enrolled in the health maintenance organization or community integrated service network at the time of an order for liquidation, the association shall issue policies to eligible individuals, without the limitation on preexisting conditions described in section 62E.14, subdivision 3.

Subd. 4. **Coverage.** Alternative coverage issued under this section must be at least a number two qualified plan, as described in section 62E.06, subdivision 2, or for individuals over age 65, a basic Medicare supplement plan, as described in section 62A.316.

Subd. 5. **Premium.** The premium for alternative coverage issued under this section must not exceed 80 percent of the premium for the comparable coverage offered by the association.

Subd. 6. **Duration.** The duration of alternative coverage issued under this section is:

(1) for individuals eligible under subdivision 2, clause (1), 90 days; and

(2) for individuals eligible under subdivision 2, clause (2), 90 days or the length of time remaining in the group contract with the insolvent health maintenance organization or community integrated service network, whichever is greater.

Subd. 7. **Replacement coverage; limitations.** The association is not obligated to offer replacement coverage under this chapter at the end of the periods specified in subdivision 6. Any continuation obligation arising under this chapter or chapter 62A will cease at the end of the periods specified in subdivision 6.

Subd. 8. **Claims expenses exceeding premiums.** Claims expenses resulting from the operation of this section which exceed premiums received shall be borne by contributing members of the association in accordance with section 62E.11, subdivision 5.

Subd. 9. **Coordination of policies.** If an insolvent health maintenance organization or community integrated service network has insolvency insurance coverage at the time of an order for liquidation, the association may coordinate the benefits of the policy issued under this section with those of the insolvency insurance policy available to the enrollees. The premium level for the combined association policy and the insolvency insurance policy may not exceed those described in subdivision 5.

62J.06 IMMUNITY FROM LIABILITY.

No member of the Health Technology Advisory Committee shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

62J.156 CLOSED COMMITTEE HEARINGS.

Notwithstanding chapter 13D, the Health Technology Advisory Committee may meet in closed session to discuss a specific technology or procedure that involves data received that have been classified as nonpublic data, where disclosure of the data would cause harm to the competitive or economic position of the source of the data.

62J.2930 INFORMATION CLEARINGHOUSE.

Subd. 4. **Coordination.** To the extent possible, the commissioner shall coordinate the activities of the clearinghouse with the activities of the Minnesota Health Data Institute.

62J.57 MINNESOTA CENTER FOR HEALTH CARE ELECTRONIC DATA INTERCHANGE.

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota Center for Health Care Electronic Data Interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota Center for Health Care Electronic Data Interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

(1) coordinating and ensuring the availability of quality electronic data interchange education and training in the state;

(2) developing an extensive, cohesive health care electronic data interchange education curriculum;

(3) developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;

(4) administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents database, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and

(5) providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

62U.10 HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.

Subd. 4. **Repayment of transfer.** When accumulated savings accruing to state-administered health care programs, as calculated under subdivision 3, meet or exceed $50,000,000, the commissioner of health shall certify that event to the commissioner of management and budget. In the next fiscal year following the certification, the commissioner of management and budget shall transfer $50,000,000 from the general fund to the health care access fund. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget.

144.9821 ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING AND RESOURCE ALLOCATION.

Subdivision 1. **Establishment of grant program.** (a) The commissioner of health shall establish an annual grant program to award infrastructure capacity building grants to help metro and rural community and faith-based organizations serving people of color, American Indians, LGBTQIA+ communities, and people living with disabilities in Minnesota who have been disproportionately impacted by health and other inequities to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) The commissioner of health shall create a framework at the department to maintain equitable practices in grantmaking to ensure that internal grantmaking and procurement policies and practices prioritize equity, transparency, and accessibility to include:

(1) a tracking system for the department to better monitor and evaluate equitable procurement and grantmaking processes and their impacts; and

(2) technical assistance and coaching to department leadership in grantmaking and procurement processes and programs and providing tools and guidance to ensure equitable and transparent competitive grantmaking processes and award distribution across communities most impacted by inequities and develop measures to track progress over time.

Subd. 2. **Commissioner's duties.** The commissioner of health shall:

(1) in consultation with community stakeholders, community health boards and Tribal nations, develop a request for proposals for an infrastructure capacity building grant program to help community-based organizations, including faith-based organizations, to be better equipped and prepared for success in procuring grants and contracts at the department and beyond;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing community-based organizations and other service providers in order to better meet statewide needs particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) in consultation with community stakeholders, review responses to requests for proposals and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, Minnesota Council on Disability, Minnesota Commission of the Deaf, DeafBlind, and Hard of Hearing, and the governor's office on the request for proposal process;

(5) in consultation with community stakeholders, establish a transparent and objective accountability process focused on outcomes that grantees agree to achieve;

(6) maintain data on outcomes reported by grantees; and

(7) establish a process or mechanism to evaluate the success of the capacity building grant program and to build the evidence base for effective community-based organizational capacity building in reducing disparities.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: organizations or entities that work with diverse communities such as people of color, American Indians, LGBTQIA+ communities, and people with disabilities in metro and rural communities.

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, shall develop a request for proposals for equity in procurement and grantmaking capacity building grant program to help community-based organizations, including faith-based organizations to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from organizations or entities led by populations of color or American Indians, and those serving communities of color, American Indians, LGBTQIA+ communities, and disability communities.

Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+, and disability communities to the extent possible.

Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

151.13 RENEWAL FEE; CONTINUING EDUCATION.

Subdivision 1. **Renewal fee.** Every person licensed by the board as a pharmacist shall pay to the board the annual renewal fee specified in section 151.065. The board may charge the late fee specified in section 151.065 if the renewal fee and application are not received by the board prior to the date specified by the board. It shall be unlawful for any person licensed as a pharmacist who refuses or fails to pay any applicable renewal or late fee to practice pharmacy in this state. Every certificate and license shall expire at the time therein prescribed.

Subd. 2. **Continuing education.** The board may appoint an advisory task force on continuing education, consisting of not more than ten members, to study continuing education programs and requirements and to submit its report and recommendations to the board. The task force shall expire, and the compensation and removal of members shall be as provided in section 15.059.

256B.69 PREPAID HEALTH PLANS.

Subd. 31a. **Trend limit; calculation.** (a) Beginning January 1, 2020, and ending June 30, 2024, the commissioner of human services may, to the extent practicable, limit the year over year increase in rates paid to managed care plans and county-based purchasing plans under this section and section 256B.692 by an amount equal to the value of a 0.8 percent reduction in rates in medical assistance across all products. Managed care rates must meet actuarial soundness and rate development requirements under Code of Federal Regulations, title 42, part 438, subpart A. Forecast expenditure growth assumptions cannot be part of the rate-setting process.

(b) In the November 2019 forecast, the commissioner of human services, in consultation with the commissioner of management and budget, shall determine the extent to which the year over year change in managed care and county-based purchasing plan rates are forecasted to reduce medical assistance expenditures in fiscal years 2020 through 2024, relative to projected expenditures from the end of the 2019 legislative session that establish a budget for the Department of Human Services. To the extent the total value of the reduction is less than $145,150,000, the commissioner of management and budget shall transfer the difference from the premium security account established in section 62E.25, subdivision 1, to the general fund.

256D.024 PERSONS PROHIBITED FROM RECEIVING BENEFITS.

Subdivision 1. **Person convicted of drug offenses.** (a) An individual who has been convicted of a felony-level drug offense during the previous ten years from the date of application or recertification may be subject to random drug testing. The county must provide information about substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

(b) For the purposes of this subdivision, "drug offense" means a conviction that occurred during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the conviction occurred during the previous ten years from the date of application or recertification and the conviction is for a crime that would be a felony if committed in Minnesota.

(c) This subdivision does not apply for convictions or positive test results related to cannabis, marijuana, or tetrahydrocannabinols.

256D.09 PAYMENT; ASSESSMENT; OVERPAYMENT.

Subd. 2a. **Vendor payments for drug dependent persons.** If, at the time of application or at any other time, there is a reasonable basis for questioning whether a person applying for or receiving financial assistance is drug dependent, as defined in section 254A.02, subdivision 5, the person shall be referred for a chemical health assessment, and only emergency assistance payments or general assistance vendor payments may be provided until the assessment is complete and the results of the assessment made available to the county agency. A reasonable basis for referring an individual for an assessment exists when:

(1) the person has required detoxification two or more times in the past 12 months;

(2) the person appears intoxicated at the county agency as indicated by two or more of the following:

(i) the odor of alcohol;

(ii) slurred speech;

(iii) disconjugate gaze;

(iv) impaired balance;

(v) difficulty remaining awake;

(vi) consumption of alcohol;

(vii) responding to sights or sounds that are not actually present;

(viii) extreme restlessness, fast speech, or unusual belligerence;

(3) the person has been involuntarily committed for drug dependency at least once in the past 12 months; or

(4) the person has received treatment, including domiciliary care, for drug abuse or dependency at least twice in the past 12 months.

The assessment and determination of drug dependency, if any, must be made by an assessor qualified under section 245G.11, subdivisions 1 and 5, to perform an assessment of chemical use. The county shall only provide emergency general assistance or vendor payments to an otherwise eligible applicant or recipient who is determined to be drug dependent, except up to 15 percent of the grant amount the person would otherwise receive may be paid in cash. Notwithstanding subdivision 1, the commissioner of human services shall also require county agencies to provide assistance only in the form of vendor payments to all eligible recipients who assert substance use disorder as a basis for eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1) and (5).

The determination of drug dependency shall be reviewed at least every 12 months. If the county determines a recipient is no longer drug dependent, the county may cease vendor payments and provide the recipient payments in cash.

Subd. 2b. **Disability verification; substance use disorder.** If at any time there is verification that the client's disability is dependent upon the client's continued drug addiction or alcoholism, general assistance for rent and utilities must be made in the form of vendor payments.

Verification of drug addiction or alcoholism can be received from:

(1) denial of Social Security benefits based on drug addiction or alcoholism;

(2) a statement from the state medical review team that the person's disability is dependent upon continued drug addiction or alcoholism; or

(3) a doctor's statement that the person's disability is dependent upon continued drug addiction or alcoholism.

2500.0100 DEFINITIONS.

Subp. 5b. **Good standing.** "Good standing" means any license which is not the subject of current disciplinary action as identified in Minnesota Statutes, section 148.10, subdivisions 1, 3, and 4. The pendency of a complaint shall not cause a license to lose good standing unless and until the complaint results in disciplinary action under Minnesota Statutes, section 148.10 or pursuant to a stipulation and order. A license shall be restored to good standing upon the satisfactory completion, expiration, or other agreed upon termination of all terms of a stipulation and order. An agreement for corrective action as described under Minnesota Statutes, section 214.103, subdivision 6, shall not cause a license to lose good standing.

Subp. 6. **Inactive license.** "Inactive license" means a restricted license that allows the licensee to maintain a license but does not allow the licensee to actively practice in Minnesota.

Subp. 12. **Voluntarily retired license.** "Voluntarily retired license" means a license which has been voluntarily surrendered by a chiropractor. It relinquishes all rights to practice chiropractic in Minnesota.

2500.1900 LICENSE REINSTATEMENT.

A license terminated by reason of the licensee's failure to comply with the continuing education requirements of parts 2500.1200 to 2500.2000, or failure to submit a completed application for license renewal as prescribed by the board, may be reinstated or restored to full status by following one of the applicable procedures in items A to E.

A. An applicant whose license has been terminated for a period of less than five years, and who can verify continual practice elsewhere during that time, shall be reinstated by completing all interim continuing education and paying all interim licensure fees that would have been required for continual licensure, paying any accrued penalty fees established in part 2500.1100, subpart 3, and repairing any other deficiencies that led to the termination.

B. An applicant whose license has been terminated for a period of greater than five years and who can verify continual practice elsewhere during that time must, in addition to following the procedures in item A, complete the board's jurisprudence examination.

C. An applicant whose license has been terminated for a period of less than five years, and who cannot verify continual practice during that time, shall be reinstated by completing all interim continuing education that would have been required for continual licensure, completing an additional ten units of approved continuing education for each intervening renewal year, paying all accrued penalty fees and interim licensure fees required for continual licensure, and repairing any other deficiencies that led to the termination.

D. An applicant whose license has been terminated for a period of greater than five years, and who cannot verify continual practice during that time, shall be reinstated by paying all accrued penalty fees and interim licensure fees that would have been required for continual licensure, repairing any other deficiencies that led to the termination, taking the board's jurisprudence examination, and completing the Special Purposes Examination in Chiropractic administered by the National Board of Chiropractic Examiners, or other examination approved by the board.

E. At the election of the applicant, the board shall waive any of the continuing education requirements in items A to C upon successful completion of the Special Purposes Examination in Chiropractic administered by the National Board of Chiropractic Examiners, or any other examination approved by the board, within 12 months preceding the application.

Any continuing education units acquired in another jurisdiction for the purposes of license renewal may be applied to item A, B, or C. None of the continuing education units obtained for the purpose of reinstating a terminated license apply to the current annual requirement. Applicants must complete a board-approved application for reinstatement.

2500.2020 INACTIVE LICENSE.

A Minnesota licensed chiropractor may apply to the board for an inactive license according to items A to C. An inactive license is intended for those chiropractors who will be in active practice elsewhere.

A. Applicants must complete a board-approved application which must include a signed affidavit stating that the applicant will no longer be actively practicing chiropractic in the state of Minnesota.

B. Upon approval of an application, the board will modify the annual license certificate to indicate inactive licensure.

C. The board may refuse to approve an application if:

(1) a pending or final disciplinary action exists against an applicant's Minnesota license;

(2) a pending or final disciplinary action exists against an applicant's license in another state where the applicant has been licensed to practice chiropractic; or

(3) the applicant's Minnesota license is not current in fees and penalties paid, or in continuing education units obtained for annual license renewal.

2500.2040 REINSTATEMENT OF INACTIVE LICENSE.

An inactive license may be reinstated to an active license according to items A to E:

A. completion of a board-approved application of reinstatement;

B. payment of a reinstatement fee in the amount of $100;

C. submission of a certification of good standing from each state the doctor was granted a license;

D. submission of a notarized statement from the doctor stating:

(1) that the doctor has remained in active practice in another state or country during the period of inactive license status in Minnesota;

(2) that the doctor has met the continuing education requirements as approved by Minnesota or the states or countries in which the doctor practiced chiropractic, or has taken at least 12 units of continuing education each year of inactive license status, whichever is greater; and

(3) the specific addresses of where the doctor has been in active practice; and

E. completion of 20 units of continuing education as approved by the board the year prior to application for reinstatement.

If any of the requirements of items A to E are not met by the doctor, the board will deny approval of the application for reinstatement.

2500.2100 VOLUNTARILY RETIRED LICENSE.

Upon request of a Minnesota licensed chiropractor, the board may place a license in voluntary retirement unless:

A. a pending or final disciplinary action exists against an applicant's Minnesota license;

B. a pending or final disciplinary action exists against an applicant's license in another state where the applicant has been licensed to practice chiropractic; or

C. the applicant's Minnesota license is not current in fees and penalties paid or in continuing education units obtained for annual license renewal.

2500.2110 REINSTATEMENT OF VOLUNTARILY RETIRED LICENSE.

A. An applicant who has voluntarily retired a license may be reinstated or restored to full status by:

(1) completing a board-approved application of reinstatement;

(2) paying a reinstatement fee in the amount of $100;

(3) submitting a certification of good standing from each state the doctor was granted a license; and

(4) following one of the applicable procedures in items B to F.

B. An applicant who has been voluntarily retired for a period of less than five years, and who can verify continual practice elsewhere during that time, shall be reinstated by completing all interim continuing education and paying all accrued penalty fees and interim licensure fees which would have been required for continual licensure, and repairing any deficiencies that occurred prior to retirement.

C. An applicant who has been voluntarily retired for a period of greater than five years who can verify continual practice elsewhere during that time must, in addition to following the procedures in items A and B, complete the board's jurisprudence examination.

D. An applicant who has been voluntarily retired for a period of less than five years, and who cannot verify continual practice during that time, shall be reinstated by completing all interim continuing education that would have been required for continual licensure, completing an additional ten units of approved continuing education for each intervening renewal year, paying all accrued penalty fees and interim licensure fees that would have been required for continual licensure, and repairing any deficiencies that occurred prior to retirement.

E. An applicant who has been voluntarily retired for a period of greater than five years, and who cannot verify continual practice during that time, shall be reinstated by paying all accrued penalty fees and interim licensure fees that would have been required for continual licensure, repairing any other deficiencies that may have occurred prior to retirement, taking the board's jurisprudence examination, and completing the Special Purposes Examination in Chiropractic administered by the National Board of Chiropractic Examiners, or any other examination the board may deem appropriate.

F. At the election of the applicant, the board shall waive any of the continuing education requirements in items B to D, upon successful completion of the Special Purposes Examination in Chiropractic administered by the National Board of Chiropractic Examiners, or other examination the board may deem appropriate, within the 12 months preceding the application.

Any continuing education units acquired in another jurisdiction, for the purposes of license renewal, may be applied to items B, C, and D. None of the continuing education units obtained for the purpose of reinstating a voluntarily retired license apply to the current annual requirement. Applicants must complete a board-approved application of reinstatement.

6800.0400 ANNUAL LICENSE RENEWAL DATE AND FEES.

Each pharmacy license shall expire on June 30 of each year and shall be renewed annually by filing an application for license renewal, on or before June 1 of each year, together with a fee established in Minnesota Statutes, chapter 151. Renewal applications received on or after July 1 are subject to a late filing fee of an amount equal to 50 percent of the renewal fee in addition to the renewal fee.

6800.1150 ANNUAL RENEWAL, FEES, AND POSTING.

A pharmacist license expires on March 1 of each year and shall be renewed annually by filing an application for license renewal on or before February 1 of each year, together

with a fee of $105. A pharmacist license renewal application received after March 1 is subject to a late filing fee of an amount equal to 50 percent of the renewal fee in addition to the renewal fee.

A pharmacist shall post the license or renewal most recently issued by the board or a copy of it in a conspicuous place within the pharmacy in which the pharmacist is practicing. For community pharmacies, this place shall be a place which is readily visible to the public.