

**SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION**

S.F. No. 476

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DATE	D-PG	OFFICIAL STATUS
01/21/2025	141	Introduction and first reading Referred to Human Services
04/01/2025	1142a 1243 6285	Comm report: To pass as amended Second reading Rule 47, returned to Human Services
04/07/2026		Comm report: To pass as amended Second reading

1.1 A bill for an act

1.2 relating to human services; modifying policy provisions relating to continuity of

1.3 care following a payment withhold, aging and disability services, adult protective

1.4 services, substance use disorder treatment, Direct Care and Treatment, and

1.5 Department of Health regulation of long-term care services; permitting certain

1.6 facilities to serve intoxicating liquor without a license; making technical and

1.7 conforming changes; requiring reports; amending Minnesota Statutes 2024, sections

1.8 3.7381; 13.04, subdivision 4a; 13.384, subdivision 1; 13.46, subdivision 1; 144.56,

1.9 subdivision 2b; 144.586, subdivision 2; 144.6502, subdivision 1; 144A.161,

1.10 subdivision 1a; 144A.472, subdivision 5; 144A.72, subdivision 2; 144G.08, by

1.11 adding subdivisions; 144G.19, by adding a subdivision; 144G.31, subdivision 6;

1.12 144G.40, subdivision 2; 144G.41, subdivisions 1, 2, by adding a subdivision;

1.13 144G.61, subdivision 2; 144G.63, subdivisions 2, 5, by adding a subdivision;

1.14 157.17, subdivisions 2, 5; 182.6545; 245A.03, by adding subdivisions; 245D.09,

1.15 subdivision 5; 245D.10, subdivision 3; 245F.02, subdivision 17; 245F.15,

1.16 subdivision 7; 245G.06, subdivision 4; 245G.11, subdivision 8; 253B.03,

1.17 subdivision 6; 253B.18, subdivision 14; 254B.052, subdivision 1, by adding a

1.18 subdivision; 256.9752, as amended; 256B.04, subdivision 24, by adding a

1.19 subdivision; 256B.056, subdivision 7a, by adding subdivisions; 256B.0625, by

1.20 adding a subdivision; 256B.064, subdivision 2; 256B.0658; 256B.0659,

1.21 subdivisions 12, 16, 17, 19; 256B.0759, subdivision 3; 256B.0911, subdivision

1.22 32; 256B.0924, subdivisions 3, 5, 7, by adding a subdivision; 256B.0949, by adding

1.23 a subdivision; 256B.4905, subdivision 2a; 256B.492, subdivisions 1, 3; 256B.85,

1.24 by adding subdivisions; 256B.851, subdivision 8; 256L.03, subdivision 1;

1.25 256R.481; 256S.205, subdivision 1; 256S.21, subdivision 3; 295.50, subdivision

1.26 4; 626.557, subdivisions 9, 9a, 12b, by adding subdivisions; 626.5572, subdivisions

1.27 2, 9, 17, by adding subdivisions; Minnesota Statutes 2025 Supplement, sections

1.28 13.46, subdivision 2; 144A.474, subdivision 11; 245C.03, subdivision 6; 245C.04,

1.29 subdivision 6; 245C.10, subdivision 6; 245D.091, subdivisions 2, 3; 245D.10,

1.30 subdivision 3a; 245F.08, subdivision 3; 245G.11, subdivision 7; 253B.18,

1.31 subdivision 6; 254A.03, subdivision 3; 254B.0501, subdivision 6; 254B.0505,

1.32 subdivision 8, by adding subdivisions; 256B.04, subdivision 21; 256B.0701,

1.33 subdivision 9; 256B.0759, subdivision 4; 256B.0911, subdivision 13; 256B.0924,

1.34 subdivision 6; 256B.0949, subdivisions 2, 16; 256B.4914, subdivisions 8, 10a;

1.35 256B.85, subdivision 7; 256S.205, subdivision 2; 295.50, subdivision 9b; 626.5572,

1.36 subdivision 13; Laws 2024, chapter 125, article 1, section 47; proposing coding

1.37 for new law in Minnesota Statutes, chapters 144A; 144G; 245D; 246C; 256B;

1.38 340A; repealing Minnesota Statutes 2024, sections 256B.051, subdivisions 1, 4,

2.1 7; 256B.0759, subdivisions 2, 5; 256B.5012, subdivisions 4, 5, 6, 7, 8, 9, 10, 11,
 2.2 12, 14, 15, 16; 626.557, subdivision 10; Minnesota Statutes 2025 Supplement,
 2.3 sections 245A.04, subdivision 7; 254B.052, subdivision 6; 256B.051, subdivisions
 2.4 2, 3, 5, 6, 6a, 6b, 8, 9, 10; Laws 2025, First Special Session chapter 3, article 18,
 2.5 section 3.

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

2.7 **ARTICLE 1**

2.8 **CONTINUITY OF CARE**

2.9 Section 1. Minnesota Statutes 2024, section 245D.10, subdivision 3, is amended to read:

2.10 Subd. 3. **Service suspension.** (a) The license holder must establish policies and
 2.11 procedures for temporary service suspension that promote continuity of care and service
 2.12 coordination with the person and the case manager and with other licensed caregivers, if
 2.13 any, who also provide support to the person. The policy must include the requirements
 2.14 specified in paragraphs (b) to (f).

2.15 (b) The license holder must limit temporary service suspension to situations in which:

2.16 (1) the person's conduct poses an imminent risk of physical harm to self or others and
 2.17 either positive support strategies have been implemented to resolve the issues leading to
 2.18 the temporary service suspension but have not been effective and additional positive support
 2.19 strategies would not achieve and maintain safety, or less restrictive measures would not
 2.20 resolve the issues leading to the suspension;

2.21 (2) the person has emergent medical issues that exceed the license holder's ability to
 2.22 meet the person's needs; or

2.23 (3) the program has not been paid for services, except an interruption to the person's
 2.24 public benefits that has lasted less than 60 days does not constitute nonpayment.

2.25 (c) Prior to giving notice of temporary service suspension, the license holder must
 2.26 document actions taken to minimize or eliminate the need for service suspension. Action
 2.27 taken by the license holder must include, at a minimum:

2.28 (1) consultation with the person's support team or expanded support team to identify
 2.29 and resolve issues leading to issuance of the notice; and

2.30 (2) a request to the case manager for intervention services identified in section 245D.03,
 2.31 subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention
 2.32 services to support the person in the program. This requirement does not apply to temporary
 2.33 suspensions issued under paragraph (b), clause (3).

3.1 If, based on the best interests of the person, the circumstances at the time of the notice were
3.2 such that the license holder was unable to take the action specified in clauses (1) and (2),
3.3 the license holder must document the specific circumstances and the reason for being unable
3.4 to do so.

3.5 (d) The notice of temporary service suspension must meet the following requirements:

3.6 (1) the license holder must notify the person or the person's legal representative and case
3.7 manager in writing of the intended temporary service suspension. If the temporary service
3.8 suspension is from residential supports and services as defined in section 245D.03,
3.9 subdivision 1, paragraph (c), clause (3), or from integrated community supports as defined
3.10 in section 245D.03, subdivision 1, paragraph (c), clause (8), the license holder must also
3.11 notify the commissioner in writing;

3.12 (2) notice of temporary service suspension must be given on the first day of the service
3.13 suspension; and

3.14 (3) the notice must include the reason for the action, a summary of actions taken to
3.15 minimize or eliminate the need for temporary service suspension as required under ~~this~~
3.16 ~~paragraph~~ paragraph (c), and why these measures failed to prevent the suspension.

3.17 (e) During the temporary suspension period, the license holder must:

3.18 (1) provide information requested by the person or case manager;

3.19 (2) work with the support team or expanded support team to develop reasonable
3.20 alternatives to protect the person and others and to support continuity of care; and

3.21 (3) maintain information about the service suspension, including the written notice of
3.22 temporary service suspension, in the service recipient record.

3.23 (f) If, based on a review by the person's support team or expanded support team, that
3.24 team determines the person no longer poses an imminent risk of physical harm to self or
3.25 others, the person has a right to return to receiving services. If, at the time of the service
3.26 suspension or at any time during the suspension, the person is receiving treatment related
3.27 to the conduct that resulted in the service suspension, the support team or expanded support
3.28 team must consider the recommendation of the licensed health professional, mental health
3.29 professional, or other licensed professional involved in the person's care or treatment when
3.30 determining whether the person no longer poses an imminent risk of physical harm to self
3.31 or others and can return to the program. If the support team or expanded support team makes
3.32 a determination that is contrary to the recommendation of a licensed professional treating

4.1 the person, the license holder must document the specific reasons why a contrary decision
4.2 was made.

4.3 Sec. 2. Minnesota Statutes 2025 Supplement, section 245D.10, subdivision 3a, is amended
4.4 to read:

4.5 Subd. 3a. **Service termination.** (a) The license holder must establish policies and
4.6 procedures for service termination that promote continuity of care and service coordination
4.7 with the person and the case manager and with other licensed caregivers, if any, who also
4.8 provide support to the person. The policy must include the requirements specified in
4.9 paragraphs (b) to (f).

4.10 (b) The license holder must permit each person to remain in the program or to continue
4.11 receiving services and must not terminate services unless:

4.12 (1) the termination is necessary for the person's welfare and the license holder cannot
4.13 meet the person's needs;

4.14 (2) the safety of the person, others in the program, or staff is endangered and positive
4.15 support strategies were attempted and have not achieved and effectively maintained safety
4.16 for the person or others;

4.17 (3) the health of the person, others in the program, or staff would otherwise be
4.18 endangered;

4.19 (4) the license holder has not been paid for services, except an interruption to a person's
4.20 public benefits that has lasted less than 60 days does not constitute nonpayment;

4.21 (5) the program or license holder ceases to operate;

4.22 (6) the person has been terminated by the lead agency from waiver eligibility; or

4.23 (7) for state-operated community-based services, the person no longer demonstrates
4.24 complex behavioral needs that cannot be met by private community-based providers
4.25 identified in section 246C.11, subdivision 4a, paragraph (a), clause (1).

4.26 (c) Prior to giving notice of service termination, the license holder must document actions
4.27 taken to minimize or eliminate the need for termination. Action taken by the license holder
4.28 must include, at a minimum:

4.29 (1) consultation with the person's support team or expanded support team to identify
4.30 and resolve issues leading to issuance of the termination notice;

5.1 (2) a request to the case manager for intervention services identified in section 245D.03,
5.2 subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention
5.3 services to support the person in the program. This requirement does not apply to notices
5.4 of service termination issued under paragraph (b), clauses (4) and (7); and

5.5 (3) for state-operated community-based services terminating services under paragraph
5.6 (b), clause (7), the state-operated community-based services must engage in consultation
5.7 with the person's support team or expanded support team to:

5.8 (i) identify that the person no longer demonstrates complex behavioral needs that cannot
5.9 be met by private community-based providers identified in section 246C.11, subdivision
5.10 4a, paragraph (a), clause (1);

5.11 (ii) provide notice of intent to issue a termination of services to the lead agency when a
5.12 finding has been made that a person no longer demonstrates complex behavioral needs that
5.13 cannot be met by private community-based providers identified in section 246C.11,
5.14 subdivision 4a, paragraph (a), clause (1);

5.15 (iii) assist the lead agency and case manager in developing a person-centered transition
5.16 plan to a private community-based provider to ensure continuity of care; and

5.17 (iv) coordinate with the lead agency to ensure the private community-based service
5.18 provider is able to meet the person's needs and criteria established in a person's
5.19 person-centered transition plan.

5.20 If, based on the best interests of the person, the circumstances at the time of the notice were
5.21 such that the license holder was unable to take the action specified in clauses (1) and (2),
5.22 the license holder must document the specific circumstances and the reason for being unable
5.23 to do so.

5.24 (d) The notice of service termination must meet the following requirements:

5.25 (1) the license holder must notify the person or the person's legal representative and the
5.26 case manager in writing of the intended service termination. If the service termination is
5.27 from residential supports and services as defined in section 245D.03, subdivision 1, paragraph
5.28 (c), clause (3), or from integrated community supports as defined in section 245D.03,
5.29 subdivision 1, paragraph (c), clause (8), the license holder must also notify the commissioner
5.30 in writing; and

5.31 (2) the notice must include:

5.32 (i) the reason for the action;

6.1 (ii) except for a service termination under paragraph (b), clause (5), a summary of actions
6.2 taken to minimize or eliminate the need for service termination or temporary service
6.3 suspension as required under paragraph (c), and why these measures failed to prevent the
6.4 termination or suspension;

6.5 (iii) the person's right to appeal the termination of services under section 256.045,
6.6 subdivision 3, paragraph (a); and

6.7 (iv) the person's right to seek a temporary order staying the termination of services
6.8 according to the procedures in section 256.045, subdivision 4a or 6, paragraph (c).

6.9 (e) Notice of the proposed termination of service, including those situations that began
6.10 with a temporary service suspension, must be given at least 90 days prior to termination of
6.11 services under paragraph (b), clause (7), 60 days prior to termination when a license holder
6.12 is providing intensive supports and services identified in section 245D.03, subdivision 1,
6.13 paragraph (c), or integrated community supports as defined in section 245D.03, subdivision
6.14 1, paragraph (c), clause (8), and 30 days prior to termination for all other services licensed
6.15 under this chapter. This notice may be given in conjunction with a notice of temporary
6.16 service suspension under subdivision 3.

6.17 (f) During the service termination notice period, the license holder must:

6.18 (1) work with the support team or expanded support team to develop reasonable
6.19 alternatives to protect the person and others and to support continuity of care;

6.20 (2) provide information requested by the person or case manager; and

6.21 (3) maintain information about the service termination, including the written notice of
6.22 intended service termination, in the service recipient record.

6.23 (g) For notices issued under paragraph (b), clause (7), the lead agency shall provide
6.24 notice to the commissioner and the Direct Care and Treatment executive board at least 30
6.25 days before the conclusion of the 90-day termination period, if an appropriate alternative
6.26 provider cannot be secured. Upon receipt of this notice, the commissioner and the executive
6.27 board shall reassess whether a private community-based service can meet the person's needs.
6.28 If the commissioner determines that a private provider can meet the person's needs, the
6.29 executive board shall, if necessary, extend notice of service termination until placement can
6.30 be made. If the commissioner determines that a private provider cannot meet the person's
6.31 needs, the executive board shall rescind the notice of service termination and re-engage
6.32 with the lead agency in service planning for the person.

7.1 (h) For state-operated community-based services, the license holder shall prioritize the
 7.2 capacity created within the existing service site by the termination of services under paragraph
 7.3 (b), clause (7), to serve persons described in section 246C.11, subdivision 4a, paragraph
 7.4 (a), clause (1).

7.5 Sec. 3. [245D.121] INTEGRATED COMMUNITY SUPPORTS; HOUSING
 7.6 ACCOUNTS REQUIRED.

7.7 (a) If payment passes between the license holder or any controlling individual of a
 7.8 licensed program and a service recipient or an entity acting on the service recipient's behalf
 7.9 for the purpose of obtaining or maintaining a living unit in a multifamily housing building
 7.10 where the license holder delivers integrated community supports and owns, leases, or has
 7.11 a direct or indirect financial relationship with the property owner, the license holder must
 7.12 for each service recipient:

7.13 (1) keep accurate accounts of all money the license holder receives from the service
 7.14 recipient or an entity acting on the service recipient's behalf;

7.15 (2) deposit all money received in a service recipient specific-account or subaccount
 7.16 dedicated to receiving and paying each service recipient's housing costs directly to the
 7.17 property owner, even if the property owner is the license holder;

7.18 (3) provide monthly and upon demand to the service recipient, or the entity acting on
 7.19 the service recipient's behalf, a statement of the amount of all money received from the
 7.20 service recipient or entity acting on the service recipient's behalf, all money deposited in
 7.21 the service recipient's account, and all withdrawals made from the service recipient's account;

7.22 (4) provide upon demand the same information described in clause (3) to the service
 7.23 recipient's case manager; and

7.24 (5) provide upon demand the same information described in clause (3) to the
 7.25 commissioner.

7.26 (b) The money in the service recipient's account must be used exclusively for expenses
 7.27 associated with the service recipient obtaining or maintaining a living unit in a multifamily
 7.28 housing building.

7.29 (c) This section continues to apply when a service recipient chooses to not receive
 7.30 services from the license holder but continues to make payments to the license holder for
 7.31 the purposes of obtaining or maintaining a living unit.

8.1 (d) The license holder must comply with the requirements of section 245A.04, subdivision
 8.2 13.

8.3 **Sec. 4. [256B.045] CONTINUITY OF CARE.**

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

8.6 (b) "Lead agency" means a county, Tribe, or managed care organization.

8.7 (c) "Residential services and supports" means any of the following services as defined
 8.8 in the brain injury, community alternative care, community access for disability inclusion,
 8.9 developmental disabilities, or elderly waiver plans:

8.10 (1) 24-hour customized living services;

8.11 (2) community residential services;

8.12 (3) customized living services;

8.13 (4) family residential services; and

8.14 (5) integrated community supports.

8.15 **Subd. 2. Department of Human Services continuity of care team; establishment.** To
 8.16 ensure the continuity of care of older adults and people with disabilities receiving residential
 8.17 services and supports following the imposition of a payment withhold under section
 8.18 256B.064, subdivision 2, the commissioner must establish and maintain a continuity of care
 8.19 team. Within existing resources, the commissioner must ensure the continuity of care team
 8.20 always has sufficient staff capacity and resources for timely compliance with the requirements
 8.21 of this subdivision.

8.22 **Subd. 3. Department of Human Services continuity of care team; duties.** (a) Upon
 8.23 notice from the commissioner under section 256B.064, subdivision 2, paragraph (i), that
 8.24 the commissioner intends to impose a payment withhold on a provider of residential services
 8.25 and supports, the continuity of care team must:

8.26 (1) identify all the provider's clients whose services might be affected by the payment
 8.27 withhold the commissioner intends to impose, including all clients paying for services from
 8.28 a source other than medical assistance;

8.29 (2) for each identified client, identify the lead agency responsible for providing case
 8.30 management or care coordination to the client;

8.31 (3) for each identified client, identify the client's case manager or care coordinator; and

9.1 (4) for each identified client, develop an initial profile of the client containing the team's
9.2 expectations regarding the services and supports the client is likely to require if the
9.3 commissioner's imposition of a payment withhold upon the provider puts the continuity of
9.4 care of the provider's clients at risk or poses a risk that the provider's clients will need to
9.5 transition to a new service provider or service setting.

9.6 After the team has completed the tasks identified in clauses (1) to (4), the team must inform
9.7 the commissioner that the team is prepared to intervene on behalf of each identified client
9.8 immediately upon imposition of the payment withhold.

9.9 (b) Upon imposition of the payment withhold, the continuity of care team must for each
9.10 identified client:

9.11 (1) inform the Office of the Ombudsman for Long-Term Care, the Office of the
9.12 Ombudsman for Mental Health and Developmental Disabilities, and the Office of the
9.13 Ombudsperson for Public Managed Care Health Care Programs, and the lead agency that
9.14 the client's services may be disrupted by actions taken by the commissioner under section
9.15 256B.064, subdivision 2, and that the lead agency must comply with the requirements of
9.16 subdivision 4;

9.17 (2) directly inform each identified client's case manager or care coordinator that the
9.18 client's services may be disrupted by actions taken by the commissioner under section
9.19 256B.064, subdivision 2; that the continuity of care team is prepared to offer assistance to
9.20 ensure the client's continuity of care; and that the case manager must comply with the
9.21 requirements of subdivision 4; and

9.22 (3) directly inform each identified client that the client's services may be disrupted by
9.23 actions taken by the commissioner under section 256B.064, subdivision 2, and that the lead
9.24 agency, the client's case manager, and the continuity of care team are already taking steps
9.25 to develop contingency plans in the event the client's services are disrupted.

9.26 Subd. 4. **Continuity of care team and lead agency shared duties.** (a) This subdivision
9.27 applies to all lead agencies regardless of whether a lead agency provides case management
9.28 directly or under contract.

9.29 (b) The continuity of care team and the lead agencies must cooperate and coordinate
9.30 with the clients' case managers to:

9.31 (1) closely monitor services delivered to identified clients of providers subject to a
9.32 payment withhold; and

10.1 (2) develop person-centered contingency plans for alternative services, service providers,
10.2 and service settings in the event a client's services are disrupted.

10.3 (c) If a lead agency fails to develop or implement a person-centered contingency plan
10.4 that ensures timely transition to alternative services, service provider, or service setting, the
10.5 continuity of care team must directly intervene and directly provide case management to
10.6 the client at the lead agency's expense. The lead agency and the client's case manager must
10.7 fully cooperate and assist the continuity of care team in the provision of case management
10.8 services at the lead agency's expense.

10.9 (d) If the lead agency or the continuity of care team does not identify alternative services,
10.10 service provider, or service setting, the continuity of care team must notify the commissioner
10.11 and the commissioner of health, if applicable, and recommend that:

10.12 (1) the commissioner of human services either determine there is a good cause under
10.13 Code of Federal Regulations, title 42, section 455.23(e) or (f), to not suspend payments
10.14 under section 256B.064, subdivision 2, or petition the district court of Ramsey County under
10.15 section 245A.13; or

10.16 (2) the commissioner of health bring an action under section 144G.20, subdivision 21.

10.17 (e) If the commissioner does not follow the recommendations of the continuity of care
10.18 team identified in paragraph (d) within 30 days of receipt of the recommendations, the
10.19 commissioner must notify the chairs and ranking minority members of the legislative
10.20 committees with jurisdiction over human services of the commissioner's decision and include
10.21 in the notice an explanation of the commissioner's rejection of the recommendations, the
10.22 number of clients who will lose services as a result of the commissioner's decision, and the
10.23 likely outcomes for the clients who will lose services.

10.24 Subd. 5. **Provider duties.** (a) The provider must fully cooperate with the lead agency
10.25 and the continuity of care team to effectuate a coordinated transfer or coordinated move for
10.26 each client who requires a new provider.

10.27 (b) Nothing in this section absolves a provider of its obligations under chapters 144G,
10.28 245A, and 245D with respect to service suspensions, service terminations, contract
10.29 terminations, and coordinated moves. The commissioner of health and the commissioner
10.30 of human services may impose any sanctions available under law for violations of a licensing
10.31 requirement even if the provider complies with paragraph (a).

11.1 Sec. 5. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

11.2 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall
11.3 determine any monetary amounts to be recovered and sanctions to be imposed upon an
11.4 individual or entity under this section. Except as provided in paragraphs (b) and (d), neither
11.5 a monetary recovery nor a sanction will be imposed by the commissioner without prior
11.6 notice and an opportunity for a hearing, according to chapter 14, on the commissioner's
11.7 proposed action, provided that the commissioner may suspend or reduce payment to an
11.8 individual or entity, except a nursing home or convalescent care facility, after notice and
11.9 prior to the hearing if in the commissioner's opinion that action is necessary to protect the
11.10 public welfare and the interests of the program.

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

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

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

11.23 (i) fraud hotline complaints;

11.24 (ii) claims data mining; and

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

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

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

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

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

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

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

12.7 (d) ~~The withholding or reduction of payments will not continue after~~ The commissioner
 12.8 ~~determines~~ must cease the withholding or reduction of payments after determining there is
 12.9 insufficient evidence of fraud by the individual or entity, after finding good cause not to
 12.10 continue withholding or reducing payments under Code of Federal Regulations, title 42,
 12.11 section 455.23(e) or (f), or after legal proceedings relating to the alleged fraud are completed,
 12.12 unless the commissioner has sent notice of intention to impose monetary recovery or
 12.13 sanctions under paragraph (a). Upon conviction for a crime related to the provision,
 12.14 management, or administration of a health service under medical assistance, a payment held
 12.15 pursuant to this section by the commissioner or a managed care organization that contracts
 12.16 with the commissioner under section 256B.035 is forfeited to the commissioner or managed
 12.17 care organization, regardless of the amount charged in the criminal complaint or the amount
 12.18 of criminal restitution ordered.

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

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

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

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

12.29 (f) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is
 12.30 to be imposed, an individual or entity may request a contested case, as defined in section
 12.31 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal
 12.32 request must be received by the commissioner no later than 30 days after the date the

13.1 notification of monetary recovery or sanction was mailed to the individual or entity. The
13.2 appeal request must specify:

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

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

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

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

13.10 (5) other information required by the commissioner.

13.11 (g) The commissioner may order an individual or entity to forfeit a fine for failure to
13.12 fully document services according to standards in this chapter and Minnesota Rules, chapter
13.13 9505. The commissioner may assess fines if specific required components of documentation
13.14 are missing. The fine for incomplete documentation shall equal 20 percent of the amount
13.15 paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000,
13.16 whichever is less. If the commissioner determines that an individual or entity repeatedly
13.17 violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to
13.18 the provision of services to program recipients and the submission of claims for payment,
13.19 the commissioner may order an individual or entity to forfeit a fine based on the nature,
13.20 severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the
13.21 value of the claims, whichever is greater.

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

13.26 (i) Prior to suspending or withholding payments to an entity providing residential services
13.27 and supports to an older adult or person with a disability, or suspending or terminating the
13.28 entity's participation in medical assistance, the commissioner must notify the Department
13.29 of Human Services continuity of care team established under section 256B.045. The
13.30 commissioner must not suspend or withhold payments to an entity providing residential
13.31 services and supports to an older adult or person with a disability or suspend or terminate
13.32 the entity's participation in the program until the continuity of care team notifies the
13.33 commissioner that the team is prepared to immediately intervene and comply with its duties

14.1 under section 256B.045 upon imposition of the commissioner's sanction. For purposes of
14.2 this paragraph, "residential services and supports" has the meaning given under section
14.3 256B.045, subdivision 1.

14.4 Sec. 6. Minnesota Statutes 2024, section 256B.492, subdivision 1, is amended to read:

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

14.7 (b) "Community-living setting" means a single-family home or multifamily dwelling
14.8 unit where a service recipient or a service recipient's family owns or rents and maintains
14.9 control over the individual unit as demonstrated by a lease agreement. Community-living
14.10 setting does not include a home or dwelling unit that the service provider of the service
14.11 recipient's services owns, operates, or leases or in which the service provider of the service
14.12 recipient's services has a direct or indirect financial interest.

14.13 (c) "Controlling individual" has the meaning given in section 245A.02, subdivision 5a.

14.14 (d) "License holder" has the meaning given in section 245A.02, subdivision 9.

14.15 Sec. 7. Minnesota Statutes 2024, section 256B.492, subdivision 3, is amended to read:

14.16 Subd. 3. **Community-living settings.** (a) Individuals receiving services under a home
14.17 and community-based waiver under section 256B.092 or 256B.49 may receive services in
14.18 community-living settings. Community-living settings must meet the requirements of
14.19 subdivision 2, paragraph (a), clause (1).

14.20 (b) For the purposes of this section, direct financial interest exists if payment passes
14.21 between the license holder or any controlling individual of a licensed program and the
14.22 service recipient or an entity acting on the service recipient's behalf for the purpose of
14.23 obtaining or maintaining a dwelling. For the purposes of this section, indirect financial
14.24 interest exists if the license holder or any controlling individual of a licensed program has
14.25 an ownership or investment interest in the entity that owns, operates, leases, or otherwise
14.26 receives payment from the service recipient or an entity acting on the service recipient's
14.27 behalf for the purpose of obtaining or maintaining a dwelling. Neither a direct nor an indirect
14.28 financial interest exists if the service recipient is receiving services from a license holder
14.29 or a licensed program that is not the license holder or a licensed program that owns, operates,
14.30 leases, or has a direct or indirect financial interest in the setting in which the service
14.31 recipient's services are being delivered.

15.1 (c) To ensure a service recipient or the service recipient's family maintains control over
15.2 the home or dwelling unit, community-living settings are subject to the following
15.3 requirements:

15.4 (1) service recipients must not be required to receive services or share services;

15.5 (2) service recipients must not be required to have a disability or specific diagnosis to
15.6 live in the community-living setting;

15.7 (3) service recipients may hire service providers of their choice;

15.8 (4) service recipients may choose whether to share their household and with whom;

15.9 (5) the home or multifamily dwelling unit must include living, sleeping, bathing, and
15.10 cooking areas;

15.11 (6) service recipients must have lockable access and egress;

15.12 (7) service recipients must be free to receive visitors and leave the settings at times and
15.13 for durations of their own choosing;

15.14 (8) leases must comply with chapter 504B;

15.15 (9) landlords must not charge different rents to tenants who are receiving home and
15.16 community-based services; and

15.17 (10) access to the greater community must be easily facilitated based on the service
15.18 recipient's needs and preferences.

15.19 (d) Nothing in this section prohibits a service recipient from having another person or
15.20 entity not affiliated with the service provider cosign a lease. Nothing in this section prohibits
15.21 a service recipient, during any period in which a service provider has cosigned the service
15.22 recipient's lease, from modifying services with an existing cosigning service provider and,
15.23 subject to the approval of the landlord, maintaining a lease cosigned by the service provider.
15.24 Nothing in this section prohibits a service recipient, during any period in which a service
15.25 provider has cosigned the service recipient's lease, from terminating services with the
15.26 cosigning service provider, receiving services from a new service provider, or, subject to
15.27 the approval of the landlord, maintaining a lease cosigned by the new service provider.

15.28 (e) A lease cosigned by a service provider meets the requirements of paragraph (b) if
15.29 the service recipient and service provider develop and implement a transition plan which
15.30 must provide that, within two years of cosigning the initial lease, the service provider shall
15.31 transfer the lease to the service recipient and other cosigners, if any.

16.1 (f) In the event the landlord has not approved the transfer of the lease within two years
 16.2 of the service provider cosigning the initial lease, the service provider must submit a
 16.3 time-limited extension request to the commissioner of human services to continue the
 16.4 cosigned lease arrangement. The extension request must include:

16.5 (1) the reason the landlord denied the transfer;

16.6 (2) the plan to overcome the denial to transfer the lease;

16.7 (3) the length of time needed to successfully transfer the lease, not to exceed an additional
 16.8 two years;

16.9 (4) a description of how the transition plan was followed, what occurred that led to the
 16.10 landlord denying the transfer, and what changes in circumstances or condition, if any, the
 16.11 service recipient experienced; and

16.12 (5) a revised transition plan to transfer the cosigned lease between the service provider
 16.13 and the service recipient to the service recipient.

16.14 (g) The commissioner must approve an extension under paragraph (f) within sufficient
 16.15 time to ensure the continued occupancy by the service recipient.

16.16 ARTICLE 2

16.17 AGING AND DISABILITY SERVICES POLICY

16.18 Section 1. Minnesota Statutes 2024, section 245A.03, is amended by adding a subdivision
 16.19 to read:

16.20 Subd. 7b. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
 16.21 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, under
 16.22 this chapter. This paragraph does not apply to child foster residence settings with residential
 16.23 program certifications for compliance with the Family First Prevention Services Act under
 16.24 section 245A.25, subdivision 1, paragraph (a). If a child foster residence setting that was
 16.25 previously exempt from the licensing moratorium under this paragraph has its Family First
 16.26 Prevention Services Act certification rescinded under section 245A.25, subdivision 9, the
 16.27 commissioner shall revoke the license according to section 245A.07.

16.28 (b) The commissioner shall not issue an initial license for adult foster care licensed under
 16.29 Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location
 16.30 that will not be the primary residence of the license holder for the entire period of licensure.
 16.31 If an adult foster care home license is issued during this moratorium, and the license holder
 16.32 changes the license holder's primary residence away from the physical location of the foster

17.1 care license, the commissioner shall revoke the license according to section 245A.07. When
 17.2 an adult resident served by the program moves out of a foster home that is not the primary
 17.3 residence of the license holder according to Minnesota Statutes 2016, section 256B.49,
 17.4 subdivision 15, paragraph (f), the county shall immediately inform the Department of Human
 17.5 Services Licensing Division. The department may decrease the statewide licensed capacity
 17.6 for adult foster care settings. Residential settings that would otherwise be subject to the
 17.7 decreased license capacity established in this paragraph must be exempt if the license holder's
 17.8 beds are occupied by residents whose primary diagnosis is mental illness and the license
 17.9 holder is certified under the requirements in subdivision 6a or section 245D.33.

17.10 (c) The commissioner shall not issue an initial license for a community residential setting
 17.11 licensed under this chapter and chapter 245D. When an adult resident served by the program
 17.12 moves out of an adult community residential setting, the county shall immediately inform
 17.13 the Department of Human Services Licensing Division. The department may decrease the
 17.14 statewide licensed capacity for community residential settings. Residential settings that
 17.15 would otherwise be subject to the decreased license capacity established in this paragraph
 17.16 must be exempt if the license holder's beds are occupied by residents whose primary diagnosis
 17.17 is mental illness and the license holder is certified under the requirements in subdivision 6a
 17.18 or section 245D.33.

17.19 (d) The commissioner shall not issue an initial license for children's residential treatment
 17.20 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
 17.21 for a program that Centers for Medicare and Medicaid Services would consider an institution
 17.22 for mental diseases. Facilities that serve only private pay clients are exempt from the
 17.23 moratorium described in this paragraph. The commissioner has the authority to manage
 17.24 existing statewide capacity for children's residential treatment services subject to the
 17.25 moratorium under this paragraph and may issue an initial license for such facilities if the
 17.26 initial license would not increase the statewide capacity for children's residential treatment
 17.27 services subject to the moratorium under this paragraph.

17.28 Sec. 2. Minnesota Statutes 2024, section 245A.03, is amended by adding a subdivision to
 17.29 read:

17.30 Subd. 7c. **Licensing moratorium exceptions.** (a) The commissioner may approve
 17.31 exceptions to the foster care and community residential settings moratoria described under
 17.32 subdivision 7b as provided in this subdivision.

17.33 (b) When approving an exception under this subdivision to the foster care or community
 17.34 residential setting moratorium described in subdivision 7b, the commissioner shall consider

18.1 the resource need determination process in subdivision 7d, the availability of foster care
 18.2 licensed beds in the geographic area in which the licensee seeks to operate, the results of
 18.3 the person's choices during the person's annual assessment and service plan review, and the
 18.4 recommendation of the local county board. The determination by the commissioner is final
 18.5 and not subject to appeal.

18.6 (c) Permissible exceptions to the moratorium include:

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

18.9 (2) new foster care licenses or community residential setting licenses determined to be
 18.10 needed by the commissioner under subdivision 7d for the closure of a nursing facility, an
 18.11 intermediate care facility for individuals with developmental disabilities, or regional treatment
 18.12 center; restructuring of state-operated services that limits the capacity of state-operated
 18.13 facilities; or movement to the community of people who no longer require the level of care
 18.14 provided in state-operated facilities as provided under section 256B.092, subdivision 13,
 18.15 or 256B.49, subdivision 24; and

18.16 (3) new foster care licenses or community residential setting licenses determined to be
 18.17 needed by the commissioner under subdivision 7d for persons requiring hospital-level care.

18.18 Sec. 3. Minnesota Statutes 2024, section 245A.03, is amended by adding a subdivision to
 18.19 read:

18.20 Subd. 7d. **Resource needs determination process.** (a) The commissioner shall determine
 18.21 the need for newly licensed foster care homes or community residential settings. As part of
 18.22 the determination, the commissioner shall consider the availability of foster care capacity
 18.23 in the area in which the licensee seeks to operate and the recommendation of the local county
 18.24 board. The determination by the commissioner is final. A determination of need is not
 18.25 required for a change in ownership at the same address.

18.26 (b) A resource need determination process, managed at the state level, using the available
 18.27 data required under section 144A.351 and other data and information must be used to
 18.28 determine where the reduced capacity determined under section 256B.493 will be
 18.29 implemented. The commissioner shall consult with the stakeholders described in section
 18.30 144A.351 and employ a variety of methods to improve the state's capacity to meet the
 18.31 informed decisions of those people who want to move out of corporate foster care or
 18.32 community residential settings, long-term service needs within budgetary limits, including
 18.33 seeking proposals from service providers or lead agencies to change service type, capacity,

19.1 or location to improve services, increase the independence of residents, and better meet
19.2 needs identified by the long-term services and supports reports and statewide data and
19.3 information.

19.4 (c) At the time of application and reapplication for licensure, the applicant and the license
19.5 holder that are subject to the moratorium or an exclusion established in subdivision 7b are
19.6 required to inform the commissioner whether the physical location where the foster care
19.7 will be provided is or will be the primary residence of the license holder for the entire period
19.8 of licensure. If the primary residence of the applicant or license holder changes, the applicant
19.9 or license holder must notify the commissioner immediately. The commissioner shall print
19.10 on the foster care license certificate whether or not the physical location is the primary
19.11 residence of the license holder.

19.12 (d) License holders of foster care homes identified under paragraph (c) that are not the
19.13 primary residence of the license holder and that also provide services in the foster care home
19.14 that are covered by a federally approved home and community-based services waiver, as
19.15 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
19.16 services licensing division that the license holder provides or intends to provide these
19.17 waiver-funded services.

19.18 (e) The commissioner may adjust capacity to address needs identified in section
19.19 144A.351. Under this authority, the commissioner may approve new licensed settings or
19.20 delicense existing settings. Delicensing of settings must be accomplished through a process
19.21 identified in section 256B.493.

19.22 (f) The commissioner must notify a license holder when its corporate foster care or
19.23 community residential setting licensed beds are reduced under this section. The notice of
19.24 reduction of licensed beds must be in writing and delivered to the license holder by certified
19.25 mail or personal service. The notice must state why the licensed beds are reduced and must
19.26 inform the license holder of its right to request reconsideration by the commissioner. The
19.27 license holder's request for reconsideration must be in writing. If mailed, the request for
19.28 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
19.29 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
19.30 reconsideration is made by personal service, it must be received by the commissioner within
19.31 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

20.1 Sec. 4. Minnesota Statutes 2025 Supplement, section 245C.03, subdivision 6, is amended
20.2 to read:

20.3 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
20.4 **seniors and individuals with disabilities and ~~providers of housing stabilization~~**
20.5 **services.** (a) For providers of services specified in the federally approved home and
20.6 community-based waiver plans under section 256B.4912 ~~and providers of housing~~
20.7 ~~stabilization services under section 256B.051~~, the commissioner shall conduct background
20.8 studies on any individual who is an owner with at least a five percent ownership stake in
20.9 the provider, an operator of the provider, or an employee or volunteer for the provider who
20.10 has direct contact with people receiving the services. The individual studied must meet the
20.11 requirements of this chapter prior to providing waiver services and as part of ongoing
20.12 enrollment.

20.13 (b) The requirements in paragraph (a) apply to consumer-directed community supports
20.14 under section 256B.4911.

20.15 (c) For purposes of this section, "operator" includes but is not limited to a managerial
20.16 officer who oversees the billing, management, or policies of the services provided.

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

20.18 Sec. 5. Minnesota Statutes 2025 Supplement, section 245C.04, subdivision 6, is amended
20.19 to read:

20.20 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
20.21 **seniors and individuals with disabilities and ~~providers of housing stabilization~~**
20.22 **services.** (a) Providers required to initiate background studies under section 245C.03,
20.23 subdivision 6, must initiate a study using the electronic system known as NETStudy 2.0
20.24 before the individual begins in a position allowing direct contact with persons served by
20.25 the provider. New providers must initiate a study under this subdivision before initial
20.26 enrollment if the provider has not already initiated background studies as part of the service
20.27 licensure requirements.

20.28 (b) Except as provided in paragraph (c), the providers must initiate a background study
20.29 annually of an individual required to be studied under section 245C.03, subdivision 6.

20.30 (c) After an initial background study under this subdivision is initiated on an individual
20.31 by a provider of both services licensed by the commissioner and the unlicensed services
20.32 under this subdivision, a repeat annual background study is not required if:

21.1 (1) the provider maintains compliance with the requirements of section 245C.07,
 21.2 paragraph (a), regarding one individual with one address and telephone number as the person
 21.3 to receive sensitive background study information for the multiple programs that depend
 21.4 on the same background study, and that the individual who is designated to receive the
 21.5 sensitive background information is capable of determining, upon the request of the
 21.6 commissioner, whether a background study subject is providing direct contact services in
 21.7 one or more of the provider's programs or services and, if so, at which location or locations;
 21.8 and

21.9 (2) the individual who is the subject of the background study provides direct contact
 21.10 services under the provider's licensed program for at least 40 hours per year so the individual
 21.11 will be recognized by a probation officer or corrections agent to prompt a report to the
 21.12 commissioner regarding criminal convictions as required under section 245C.05, subdivision
 21.13 7.

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

21.15 Sec. 6. Minnesota Statutes 2025 Supplement, section 245C.10, subdivision 6, is amended
 21.16 to read:

21.17 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
 21.18 **seniors and individuals with disabilities and ~~providers of housing stabilization~~**
 21.19 **services.** The commissioner shall recover the cost of background studies initiated by
 21.20 unlicensed home and community-based waiver providers of service to seniors and individuals
 21.21 with disabilities under section 256B.4912 ~~and providers of housing stabilization services~~
 21.22 ~~under section 256B.051~~ through a fee of no more than \$44 per study.

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

21.24 Sec. 7. Minnesota Statutes 2024, section 245D.09, subdivision 5, is amended to read:

21.25 Subd. 5. **Annual training.** (a) A license holder must provide annual training to direct
 21.26 support staff on the topics identified in subdivision 4, clauses (3) to (11). A license holder
 21.27 may delay annual training up to 90 calendar days following the date by which the direct
 21.28 care staff would otherwise be required to receive the annual training.

21.29 (b) If the direct support staff has a first aid certification, annual training under subdivision
 21.30 4, clause (9), is not required as long as the certification remains current.

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

22.1 Sec. 8. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 2, is amended
22.2 to read:

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

22.8 (1) ethical considerations;

22.9 (2) functional assessment;

22.10 (3) functional analysis;

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

22.12 (5) selecting intervention outcomes and strategies;

22.13 (6) behavior reduction and elimination strategies that promote least restrictive approved
22.14 alternatives;

22.15 (7) data collection;

22.16 (8) staff and caregiver training;

22.17 (9) support plan monitoring;

22.18 (10) co-occurring mental disorders or neurocognitive disorder;

22.19 (11) demonstrated expertise with populations being served; and

22.20 (12) must be a:

22.21 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
22.22 of Psychology competencies in the above identified areas;

22.23 (ii) clinical social worker licensed as an independent clinical social worker under chapter
22.24 148E, or a person with a master's degree in social work from an accredited college or
22.25 university, with at least 4,000 hours of post-master's supervised experience in the delivery
22.26 of clinical services in the areas identified in clauses (1) to (11);

22.27 (iii) physician licensed under chapter 147 and certified by the American Board of
22.28 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
22.29 in the areas identified in clauses (1) to (11);

23.1 (iv) licensed professional clinical counselor licensed under sections ~~148B.29 to 148B.39~~
 23.2 148B.5301 and 148B.532 with at least 4,000 hours of post-master's supervised experience
 23.3 in the delivery of clinical services who has demonstrated competencies in the areas identified
 23.4 in clauses (1) to (11);

23.5 (v) person with a master's degree from an accredited college or university in one of the
 23.6 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised
 23.7 experience in the delivery of clinical services with demonstrated competencies in the areas
 23.8 identified in clauses (1) to (11);

23.9 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
 23.10 fields with demonstrated expertise in positive support services, as determined by the person's
 23.11 needs as outlined in the person's assessment summary;

23.12 (vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is
 23.13 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
 23.14 mental health nursing by a national nurse certification organization, or who has a master's
 23.15 degree in nursing or one of the behavioral sciences or related fields from an accredited
 23.16 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
 23.17 experience in the delivery of clinical services; or

23.18 (viii) person who has completed a competency-based training program as determined
 23.19 by the commissioner.

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

23.21 Sec. 9. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 3, is amended
 23.22 to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.1 Sec. 10. Minnesota Statutes 2024, section 256.9752, as amended by Laws 2025, First
 25.2 Special Session chapter 9, article 1, sections 6 and 7, is amended to read:

25.3 **256.9752 SENIOR NUTRITION PROGRAMS.**

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

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

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

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

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

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

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

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

25.32 Subd. 3. **Nutrition support services.** (a) Funds allocated to an area agency on aging
 25.33 for nutrition support services may be used for the following, as determined appropriate by

26.1 the area agency on aging to address the needs of older adults in the agency's planning and
 26.2 service area:

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

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

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

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

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

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

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

26.13 (8) medically tailored meals;

26.14 ~~(8)~~ (9) other appropriate services ~~which~~ and tools that support senior nutrition programs,
 26.15 including new service delivery models and technology; and

26.16 ~~(9)~~ (10) development and implementation of innovative models ~~of providing~~ to provide
 26.17 healthy and nutritious ~~meals to seniors~~ food to older adults, including through partnerships
 26.18 with schools, restaurants, hospitals, food shelves and food pantries, farmers, and other
 26.19 community partners.

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

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

26.24 Sec. 11. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
 26.25 to read:

26.26 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct
 26.27 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
 26.28 E. A provider must enroll each provider-controlled location where direct services are
 26.29 provided. The commissioner may deny a provider's incomplete application if a provider
 26.30 fails to respond to the commissioner's request for additional information within 60 days of
 26.31 the request. The commissioner must conduct a background study under chapter 245C,

27.1 including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses
27.2 (1) to (5), for a provider described in this paragraph. The background study requirement
27.3 may be satisfied if the commissioner conducted a fingerprint-based background study on
27.4 the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph
27.5 (a), clauses (1) to (5).

27.6 (b) The commissioner shall revalidate:

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

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

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

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

27.13 (c) The commissioner shall conduct revalidation as follows:

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

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

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

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

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

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

28.1 (g) An enrolled provider that is also licensed by the commissioner under chapter 245A,
28.2 is licensed as a home care provider by the Department of Health under chapter 144A, or is
28.3 licensed as an assisted living facility under chapter 144G and has a home and
28.4 community-based services designation on the home care license under section 144A.484,
28.5 must designate an individual as the entity's compliance officer. The compliance officer
28.6 must:

28.7 (1) develop policies and procedures to assure adherence to medical assistance laws and
28.8 regulations and to prevent inappropriate claims submissions;

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

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

28.13 (4) use evaluation techniques to monitor compliance with medical assistance laws and
28.14 regulations;

28.15 (5) promptly report to the commissioner any identified violations of medical assistance
28.16 laws or regulations; and

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

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

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

28.32 (i) The commissioner shall terminate or deny the enrollment of any individual or entity
28.33 if the individual or entity has been terminated from participation in Medicare or under the

29.1 Medicaid program or Children's Health Insurance Program of any other state. The
29.2 commissioner may exempt a rehabilitation agency from termination or denial that would
29.3 otherwise be required under this paragraph, if the agency:

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

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

29.8 (3) serves primarily a pediatric population.

29.9 (j) As a condition of enrollment in medical assistance, the commissioner shall require
29.10 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
29.11 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
29.12 Services, its agents, or its designated contractors and the state agency, its agents, or its
29.13 designated contractors to conduct unannounced on-site inspections of any provider location.
29.14 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
29.15 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
29.16 and standards used to designate Medicare providers in Code of Federal Regulations, title
29.17 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
29.18 The commissioner's designations are not subject to administrative appeal.

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

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

30.1 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
 30.2 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
 30.3 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
 30.4 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
 30.5 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
 30.6 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
 30.7 fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions
 30.8 from a surety bond must occur within six years from the date the debt is affirmed by a final
 30.9 agency decision. An agency decision is final when the right to appeal the debt has been
 30.10 exhausted or the time to appeal has expired under section 256B.064.

30.11 (3) "Durable medical equipment provider or supplier" means a medical supplier that can
 30.12 purchase medical equipment or supplies for sale or rental to the general public and is able
 30.13 to perform or arrange for necessary repairs to and maintenance of equipment offered for
 30.14 sale or rental.

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

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

30.28 Sec. 12. Minnesota Statutes 2024, section 256B.04, subdivision 24, is amended to read:

30.29 Subd. 24. **Medicaid waiver requests and state plan amendments; notice; public**
 30.30 **comments.** (a) The commissioner shall notify the chairs and ranking minority members of
 30.31 the legislative committees with jurisdiction over medical assistance at least 30 days before
 30.32 submitting a new Medicaid waiver request to the federal government.

30.33 (b) Prior to submitting any Medicaid waiver request or Medicaid state plan amendment
 30.34 to the federal government for approval, the commissioner shall publish the text of the waiver

31.1 request or state plan amendment, and a summary of and explanation of the need for the
 31.2 request, on the agency's website and provide a 30-day public comment period. The
 31.3 commissioner shall notify the public of the availability of this information through the
 31.4 agency's electronic subscription service. The commissioner shall publish the text of all
 31.5 public comments on the agency's website and consider public comments when preparing
 31.6 the final waiver request or state plan amendment that is to be submitted to the federal
 31.7 government for approval.

31.8 (c) The commissioner shall also publish on the agency's website notice of any federal
 31.9 decision related to the state request for approval, within 30 days of the decision. This notice
 31.10 must describe any modifications to the state request that have been agreed to by the
 31.11 commissioner as a condition of receiving federal approval.

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

31.13 Sec. 13. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision
 31.14 to read:

31.15 **Subd. 24a. Medicaid waiver requests and state plan amendments; prohibited**
 31.16 **actions.** The commissioner must not take the following actions without prior enactment of
 31.17 legislative authorization:

31.18 (1) terminate a medical assistance program, waiver, or benefit;

31.19 (2) request federal assistance with terminating a medical assistance program, waiver, or
 31.20 benefit; or

31.21 (3) substantially redesign a medical assistance program, waiver, or benefit.

31.22 Sec. 14. Minnesota Statutes 2024, section 256B.056, subdivision 7a, is amended to read:

31.23 **Subd. 7a. Periodic renewal of eligibility.** (a) The commissioner shall make an annual
 31.24 redetermination of eligibility based on information contained in the enrollee's case file and
 31.25 other information available to the agency, including but not limited to information accessed
 31.26 through an electronic database, without requiring the enrollee to submit any information
 31.27 when sufficient data is available for the agency to renew eligibility.

31.28 (b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the
 31.29 commissioner must provide the enrollee with a prepopulated renewal form containing
 31.30 eligibility information available to the agency and permit the enrollee to submit the form
 31.31 with any corrections or additional information to the agency and sign the renewal form via
 31.32 any of the modes of submission specified in section 256B.04, subdivision 18.

32.1 (c) An enrollee who is terminated for failure to complete the renewal process may
 32.2 subsequently submit the renewal form and required information within four months after
 32.3 the date of termination and have coverage reinstated without a lapse, if otherwise eligible
 32.4 under this chapter. The local agency may close the enrollee's case file if the required
 32.5 information is not submitted within four months of termination.

32.6 ~~(d) Notwithstanding paragraph (a), a person who is eligible under subdivision 5 shall~~
 32.7 ~~be subject to a review of the person's income every six months.~~

32.8 Sec. 15. Minnesota Statutes 2024, section 256B.056, is amended by adding a subdivision
 32.9 to read:

32.10 Subd. 7b. Periodic renewal of eligibility; individuals with excess
 32.11 income. Notwithstanding subdivision 7a, paragraph (a), a person who has excess income
 32.12 but is eligible under subdivision 5 is subject to a review of the person's income every six
 32.13 months.

32.14 Sec. 16. Minnesota Statutes 2024, section 256B.056, is amended by adding a subdivision
 32.15 to read:

32.16 Subd. 7c. Periodic renewal of eligibility; employed persons with disabilities. (a) For
 32.17 a person enrolled in medical assistance under section 256B.057, subdivision 9, the
 32.18 commissioner or local agency must provide the enrollee with the renewal form described
 32.19 in subdivision 7a, paragraph (b), at least 60 calendar days before the end of the enrollee's
 32.20 eligibility period. If the commissioner or local agency fails to provide the enrollee with the
 32.21 renewal form 60 calendar days before the end of the enrollee's eligibility period, consistent
 32.22 with Code of Federal Regulations, title 42, sections 435.912(e) and (g)(2), the commissioner
 32.23 and the local agency must not terminate the enrollee until the end of the second month
 32.24 following the month in which the enrollee's eligibility period ended.

32.25 (b) For a person enrolled in medical assistance under section 256B.057, subdivision 9,
 32.26 who due to a good cause is unable to respond within the required time frame to the renewal
 32.27 form provided to the enrollee under subdivision 7a, paragraph (b), the commissioner must
 32.28 provide the enrollee an additional 30 calendar days to respond, as permitted under Code of
 32.29 Federal Regulations, title 42, section 435.912(e)(1).

32.30 (c) For a person enrolled in medical assistance under section 256B.057, subdivision 9,
 32.31 the commissioner must not terminate the enrollee's medical assistance eligibility until the
 32.32 commissioner has provided the enrollee with a notice of terminated eligibility that includes
 32.33 information on the enrollee's right to appeal the termination under section 256.045.

33.1 Sec. 17. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision
33.2 to read:

33.3 Subd. 77. **Early intensive developmental and behavioral intervention benefit.** Medical
33.4 assistance covers early intensive developmental and behavioral intervention services
33.5 according to section 256B.0949.

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

33.7 Sec. 18. Minnesota Statutes 2024, section 256B.0658, is amended to read:

33.8 **256B.0658 HOUSING ACCESS GRANTS.**

33.9 Subdivision 1. **Establishment.** The commissioner of human services shall award through
33.10 a competitive process contracts for grants to public and private agencies to support and
33.11 assist individuals with a disability ~~as defined in section 256B.051, subdivision 2, paragraph~~
33.12 ~~(e)~~, to access housing.

33.13 Subd. 2. **Definition.** (a) For the purposes of this section, the term defined in this
33.14 subdivision has the meaning given.

33.15 (b) "Individual with a disability" means:

33.16 (1) an individual who is aged, blind, or disabled as determined by the criteria under
33.17 sections 216(i)(1) and 221 of the Social Security Act; or

33.18 (2) an individual who meets a category of eligibility under section 256D.05, subdivision
33.19 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

33.20 Subd. 3. **Allowable uses of grant money.** Grants may be awarded to agencies that may
33.21 include, but are not limited to, the following supports: assessment to ensure suitability of
33.22 housing, accompanying an individual to look at housing, filling out applications and rental
33.23 agreements, meeting with landlords, helping with Section 8 or other program applications,
33.24 helping to develop a budget, obtaining furniture and household goods, if necessary, and
33.25 assisting with any problems that may arise with housing.

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

33.27 Sec. 19. Minnesota Statutes 2024, section 256B.0659, subdivision 12, is amended to read:

33.28 Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal
33.29 care assistance services for a recipient must be documented daily by each personal care
33.30 assistant, on a time sheet form approved by the commissioner. All documentation may be

34.1 web-based, electronic, or paper documentation. The completed form must be submitted on
 34.2 a monthly basis to the provider and kept in the recipient's health record.

34.3 (b) The activity documentation must correspond to the personal care assistance care plan
 34.4 and be reviewed by the qualified professional.

34.5 (c) The personal care assistant time sheet must be on a form approved by the
 34.6 commissioner documenting time the personal care assistant provides services in the home.
 34.7 The following criteria must be included in the time sheet:

34.8 (1) full name of personal care assistant and individual provider number;

34.9 (2) provider name and telephone numbers;

34.10 (3) full name of recipient and either the recipient's medical assistance identification
 34.11 number or date of birth;

34.12 (4) consecutive dates, including month, day, and year, and arrival and departure times
 34.13 with a.m. or p.m. notations;

34.14 (5) signatures of recipient or the responsible party;

34.15 (6) personal signature of the personal care assistant;

34.16 (7) any shared ~~care~~ services provided, if applicable;

34.17 (8) a statement that it is a federal crime to provide false information on personal care
 34.18 service billings for medical assistance payments;

34.19 (9) dates and location of recipient stays in a hospital, care facility, or incarceration; and

34.20 (10) any time spent traveling, as described in subdivision 1, paragraph (i), including
 34.21 start and stop times with a.m. and p.m. designations, the origination site, and the destination
 34.22 site.

34.23 Sec. 20. Minnesota Statutes 2024, section 256B.0659, subdivision 16, is amended to read:

34.24 Subd. 16. **Shared services.** (a) Medical assistance payments for ~~shared~~ personal care
 34.25 assistance services that are shared services are limited according to this subdivision.

34.26 (b) ~~Shared service is~~ For the purposes of this section, "shared services" means the
 34.27 provision of personal care assistance services by a personal care assistant to two or three
 34.28 recipients; who are all eligible for medical assistance; and who each voluntarily enter into
 34.29 an agreement to receive services at the same time and in the same setting.

34.30 (c) For the purposes of this subdivision, "setting" means:

35.1 (1) the home residence or family foster care home of one or more of the individual
35.2 recipients; or

35.3 (2) a child care program licensed under chapter 142B or operated by a local school
35.4 district or private school.

35.5 (d) Shared ~~personal care assistance~~ services follow the same criteria for covered services
35.6 as subdivision 2.

35.7 (e) Noncovered shared ~~personal care assistance~~ services include the following:

35.8 (1) services for more than three recipients by one personal care assistant at one time;

35.9 (2) staff requirements for child care programs under chapter 245C;

35.10 (3) caring for multiple recipients in more than one setting;

35.11 (4) additional units of personal care assistance based on the selection of the option; and

35.12 (5) use of more than one personal care assistance provider agency for the shared ~~care~~
35.13 services.

35.14 (f) The option of shared ~~personal care assistance~~ services is elected by the recipient or
35.15 the responsible party with the assistance of the assessor. The option must be determined
35.16 appropriate based on the ages of the recipients, compatibility, and coordination of their
35.17 assessed care needs. The recipient or the responsible party, in conjunction with the qualified
35.18 professional, shall arrange the setting and grouping of shared services based on the individual
35.19 needs and preferences of the recipients. The personal care assistance provider agency shall
35.20 offer the recipient or the responsible party the option of shared services or one-on-one
35.21 personal care assistance services or a combination of both. The recipient or the responsible
35.22 party may withdraw from participating in a shared services arrangement at any time.

35.23 (g) Authorization for the shared service option must be determined by the commissioner
35.24 based on the criteria that the shared service is appropriate to meet all of the recipients' needs
35.25 and ~~their~~ the recipients' health and safety is maintained. The authorization of shared services
35.26 is part of the overall authorization of personal care assistance services. Nothing in this
35.27 subdivision must be construed to reduce the total number of hours authorized for an individual
35.28 recipient.

35.29 (h) A personal care assistant providing shared ~~personal care assistance~~ services must:

35.30 (1) receive training specific for each recipient served; and

35.31 (2) follow all required documentation requirements for time and services provided.

36.1 (i) A qualified professional shall:

36.2 (1) evaluate the ability of the personal care assistant to provide services ~~for all of~~ to all
36.3 the recipients in a shared setting;

36.4 (2) visit the shared setting as shared services are being provided at least once every six
36.5 months or whenever needed for response to a recipient's request for increased supervision
36.6 of the personal care assistance staff;

36.7 (3) provide ongoing monitoring and evaluation of the effectiveness and appropriateness
36.8 of the shared services;

36.9 (4) develop a contingency plan with each of the recipients ~~which~~ that accounts for absence
36.10 of the recipient in a shared services setting due to illness or other circumstances;

36.11 (5) obtain permission from each of the recipients who are sharing a personal care assistant
36.12 for number of shared hours for services provided inside and outside the home residence;
36.13 and

36.14 (6) document the training completed by the personal care assistants specific to the shared
36.15 setting and recipients sharing services.

36.16 Sec. 21. Minnesota Statutes 2024, section 256B.0659, subdivision 17, is amended to read:

36.17 Subd. 17. **Shared services; rates.** (a) For the purposes of this subdivision, "additional
36.18 revenue for shared services" means the difference between the rate paid to a personal care
36.19 assistance provider agency for serving a single recipient and the sum of the rates paid to a
36.20 personal care assistance provider agency for shared services provided to more than one
36.21 recipient.

36.22 (b) For the purposes of this subdivision, "wages and wage-related costs" means increased
36.23 wages and any corresponding increase in the employer's share of FICA taxes, Medicare
36.24 taxes, state and federal unemployment taxes, workers' compensation premiums, and
36.25 contributions to employee retirement accounts if the contribution is a function of wages.

36.26 (c) The commissioner shall provide a rate system for shared ~~personal care assistance~~
36.27 services. For two ~~persons~~ recipients sharing services, the rate paid to a personal care
36.28 assistance provider agency for the shared services must not exceed one and one-half times
36.29 the rate paid for serving a single ~~individual~~, and recipient. For three ~~persons~~ recipients
36.30 sharing services, the rate paid to a personal care assistance provider agency for the shared
36.31 services must not exceed twice the rate paid for serving a single ~~individual~~ recipient. These

37.1 rates apply only when all of the criteria for the shared care ~~personal care assistance service~~
 37.2 ~~have been~~ services are met.

37.3 (d) Of the additional revenue for shared services provided to two recipients, the personal
 37.4 care assistance provider agency must use 95 percent for the purposes specified in paragraph
 37.5 (e). Of the additional revenue for shared services provided to three recipients, the personal
 37.6 care assistance provider agency must use 95 percent for the purposes specified in paragraph
 37.7 (e).

37.8 (e) A personal care assistance provider agency must use the percentages of additional
 37.9 revenue for shared services specified in paragraph (d) for the wages and wage-related costs
 37.10 of the personal care assistant providing the shared services. The personal care assistance
 37.11 provider agency must not use additional revenue for shared services to pay for mileage
 37.12 reimbursements, uniform allowances, health and dental insurance, life insurance, disability
 37.13 insurance, long-term care insurance, contributions to employee retirement accounts if the
 37.14 contribution is not a function of wages, or any other employee benefits.

37.15 Sec. 22. Minnesota Statutes 2024, section 256B.0659, subdivision 19, is amended to read:

37.16 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under
 37.17 personal care assistance choice, the recipient or responsible party shall:

37.18 (1) recruit, hire, schedule, and terminate personal care assistants according to the terms
 37.19 of the written agreement required under subdivision 20, paragraph (a);

37.20 (2) develop a personal care assistance care plan based on the assessed needs and
 37.21 addressing the health and safety of the recipient with the assistance of a qualified professional
 37.22 as needed;

37.23 (3) orient and train the personal care assistant with assistance as needed from the qualified
 37.24 professional;

37.25 (4) supervise and evaluate the personal care assistant with the qualified professional,
 37.26 who is required to visit the recipient at least every 180 days;

37.27 (5) monitor and verify in writing and report to the personal care assistance choice agency
 37.28 the number of hours worked by the personal care assistant and the qualified professional;

37.29 (6) engage in an annual reassessment as required in subdivision 3a to determine
 37.30 continuing eligibility and service authorization;

37.31 (7) use the same personal care assistance choice provider agency if shared ~~personal~~
 37.32 ~~assistance care is~~ services are being used; and

38.1 (8) ensure that a personal care assistant driving the recipient under subdivision 1,
38.2 paragraph (i), has a valid driver's license and the vehicle used is registered and insured
38.3 according to Minnesota law.

38.4 (b) The personal care assistance choice provider agency shall:

38.5 (1) meet all personal care assistance provider agency standards;

38.6 (2) enter into a written agreement with the recipient, responsible party, and personal
38.7 care assistants;

38.8 (3) not be related as a parent, child, sibling, or spouse to the recipient or the personal
38.9 care assistant; and

38.10 (4) ensure arm's-length transactions without undue influence or coercion with the recipient
38.11 and personal care assistant.

38.12 (c) The duties of the personal care assistance choice provider agency are to:

38.13 (1) be the employer of the personal care assistant and the qualified professional for
38.14 employment law and related regulations including but not limited to purchasing and
38.15 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
38.16 and liability insurance, and submit any or all necessary documentation including but not
38.17 limited to workers' compensation, unemployment insurance, and labor market data required
38.18 under section 256B.4912, subdivision 1a;

38.19 (2) bill the medical assistance program for personal care assistance services and qualified
38.20 professional services;

38.21 (3) request and complete background studies that comply with the requirements for
38.22 personal care assistants and qualified professionals;

38.23 (4) pay the personal care assistant and qualified professional based on actual hours of
38.24 services provided;

38.25 (5) withhold and pay all applicable federal and state taxes;

38.26 (6) verify and keep records of hours worked by the personal care assistant and qualified
38.27 professional;

38.28 (7) make the arrangements and pay taxes and other benefits, if any, and comply with
38.29 any legal requirements for a Minnesota employer;

38.30 (8) enroll in the medical assistance program as a personal care assistance choice agency;
38.31 and

39.1 (9) enter into a written agreement as specified in subdivision 20 before services are
39.2 provided.

39.3 Sec. 23. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is
39.4 amended to read:

39.5 Subd. 9. **Provider qualifications and duties.** A provider is eligible for reimbursement
39.6 under this section only if the provider:

39.7 (1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk
39.8 assessment under subdivision 10;

39.9 (2) is enrolled as a medical assistance Minnesota health care program provider and meets
39.10 all applicable provider standards and requirements;

39.11 ~~(3) demonstrates compliance with federal and state laws and policies for housing
39.12 stabilization services as determined by the commissioner;~~

39.13 (3) demonstrates compliance with federal and state laws and policies for recuperative
39.14 care services as determined by the commissioner;

39.15 (4) complies with background study requirements under chapter 245C and maintains
39.16 documentation of background study requests and results;

39.17 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
39.18 determined by the commissioner, proof of surety bond coverage for each business location
39.19 providing services. Upon new enrollment, or if the provider's medical assistance revenue
39.20 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
39.21 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
39.22 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
39.23 must be in a form approved by the commissioner, must be renewed annually, and must
39.24 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain
39.25 monetary recovery or sanctions from a surety bond must occur within six years from the
39.26 date the debt is affirmed by a final agency decision. An agency decision is final when the
39.27 right to appeal the debt has been exhausted or the time to appeal has expired under section
39.28 256B.064;

39.29 (6) ensures all controlling individuals and employees of the agency complete annual
39.30 vulnerable adult training;

39.31 (7) completes compliance training as required under subdivision 11; and

39.32 (8) complies with the habitability inspection requirements in subdivision 13.

40.1 Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 13, is
40.2 amended to read:

40.3 Subd. 13. **MnCHOICES assessor qualifications, training, and certification.** (a) The
40.4 commissioner shall develop and implement a curriculum and an assessor certification
40.5 process.

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

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

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

40.11 (3) be a registered nurse.

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

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

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

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

40.20 Sec. 25. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

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

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

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

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

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

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

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

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

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

41.11 Sec. 26. Minnesota Statutes 2024, section 256B.0924, subdivision 3, is amended to read:

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

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

41.16 (1) be age 18 or older;

41.17 (2) be receiving medical assistance;

41.18 (3) have significant functional limitations; and

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

41.21 (b) Except as permitted under paragraph (c), the person must be:

41.22 (1) a vulnerable adult in need of adult protection as defined in section 626.5572, or is;

41.23 (2) an adult with a developmental disability as defined in section 252A.02, subdivision
 41.24 2, or;

41.25 (3) an adult with a related condition as defined in section 256B.02, subdivision 11, and
 41.26 who is not receiving home and community-based waiver services; or

41.27 is (4) an adult who lacks a permanent residence and who has been without a permanent
 41.28 residence for at least one year or on at least four occasions in the last three years.

41.29 (c) Tribal agencies may make a determination of eligibility under Tribal governance
 41.30 codes for adult protection or policy procedures consistent with section 626.5572 when

42.1 determining whether a person is a vulnerable adult in need of adult protection or an adult
 42.2 with developmental disabilities or a related condition.

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

42.5 Sec. 27. Minnesota Statutes 2024, section 256B.0924, subdivision 5, is amended to read:

42.6 Subd. 5. **Provider standards.** County boards ~~or~~₂ providers who contract with the county,
 42.7 or Tribal government contracted providers are eligible to receive medical assistance
 42.8 reimbursement for adult targeted case management services. To qualify as a provider of
 42.9 targeted case management services the vendor must:

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

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

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

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

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

42.19 (6) coordinate with county social ~~service~~ services or Tribal human services agencies
 42.20 responsible for planning for community social services under chapters 256E and 256F;
 42.21 conducting adult protective investigations under section 626.557, and conducting prepetition
 42.22 screenings for commitments under section 253B.07;

42.23 (7) coordinate with health care providers to ensure access to necessary health care
 42.24 services;

42.25 (8) have a procedure in place that notifies the recipient and the recipient's legal
 42.26 representative of any conflict of interest if the contracted targeted case management service
 42.27 provider also provides the recipient's services and supports and provides information on all
 42.28 potential conflicts of interest and obtains the recipient's informed consent and provides the
 42.29 recipient with alternatives; and

42.30 (9) have demonstrated the capacity to achieve the following performance outcomes:
 42.31 access, quality, and consumer satisfaction.

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

43.3 Sec. 28. Minnesota Statutes 2024, section 256B.0924, is amended by adding a subdivision
 43.4 to read:

43.5 **Subd. 5a. Tribal case manager qualifications.** An individual is authorized to serve as
 43.6 a vulnerable adult and developmental disability targeted case manager if the individual is
 43.7 certified by a federally recognized Tribal government in Minnesota pursuant to section
 43.8 256B.02, subdivision 7, paragraph (c).

43.9 Sec. 29. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is
 43.10 amended to read:

43.11 **Subd. 6. Payment for targeted case management.** (a) Medical assistance and
 43.12 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
 43.13 In order to receive payment for an eligible adult, the provider must document at least one
 43.14 contact per month and not more than two consecutive months without a face-to-face contact
 43.15 either in person or by interactive video that meets the requirements in section 256B.0625,
 43.16 subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver,
 43.17 or other relevant persons identified as necessary to the development or implementation of
 43.18 the goals of the personal service plan.

43.19 (b) Except as provided under paragraph (m), payment for targeted case management
 43.20 provided by county staff under this subdivision shall be based on the monthly rate
 43.21 methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one
 43.22 combined average rate together with adult mental health case management under section
 43.23 256B.0625, subdivision 20, ~~except for calendar year 2002. In calendar year 2002, the rate~~
 43.24 ~~for case management under this section shall be the same as the rate for adult mental health~~
 43.25 ~~case management in effect as of December 31, 2001.~~ Billing and payment must identify the
 43.26 recipient's primary population group to allow tracking of revenues.

43.27 (c) Payment for targeted case management provided by county-contracted vendors shall
 43.28 be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2.
 43.29 Payment for case management provided by vendors who contract with a Tribe must be made
 43.30 in accordance with Indian health service facility requirements. If a Tribe chooses to contract
 43.31 with a vendor not receiving payment through an Indian health service facility, the rate must
 43.32 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
 43.33 by the vendor for the same service to other payers. If the service is provided by a team of

44.1 contracted vendors, the team shall determine how to distribute the rate among its members.
44.2 No reimbursement received by contracted vendors shall be returned to the county or Tribe,
44.3 except to reimburse the county or Tribe for advance funding provided by the county or
44.4 Tribe to the vendor.

44.5 (d) If the service is provided by a team that includes any combination of contracted
44.6 vendors ~~and~~, county staff, and Tribal staff, the costs for county staff participation on the
44.7 team shall be included in the rate for county-provided services. In this case, the contracted
44.8 vendor and the county and Tribal case managers may each receive separate payment for
44.9 services provided by each entity in the same month. In order to prevent duplication of
44.10 services, ~~the county~~ each entity must document, ~~in the recipient's file~~, the need for team
44.11 targeted case management and a description of the different roles of ~~the team members~~ staff.

44.12 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
44.13 targeted case management shall be provided by the recipient's county of responsibility, as
44.14 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
44.15 used to match other federal funds. If the service is provided by a Tribal agency, the recipient's
44.16 Tribe must provide the nonfederal share of costs, if any.

44.17 (f) The commissioner may suspend, reduce, or terminate reimbursement to a provider
44.18 that does not meet the reporting or other requirements of this section. The county of
44.19 responsibility, as defined in sections 256G.01 to 256G.12, or Tribe when applicable, is
44.20 responsible for any federal disallowances. The county may share this responsibility with
44.21 its contracted vendors.

44.22 (g) The commissioner shall set aside five percent of the federal funds received under
44.23 this section for use in reimbursing the state for costs of developing and implementing this
44.24 section.

44.25 (h) Payments to counties and Tribes for targeted case management expenditures under
44.26 this section shall only be made from federal earnings from services provided under this
44.27 section. Payments to contracted vendors shall include both the federal earnings and the
44.28 county share.

44.29 (i) Notwithstanding section 256B.041, county or Tribal payments for the cost of case
44.30 management services provided by county or Tribal staff shall not be made to the
44.31 commissioner of management and budget. For the purposes of targeted case management
44.32 services provided by county or Tribal staff under this section, the centralized disbursement
44.33 of payments to counties or Tribes under section 256B.041 consists only of federal earnings
44.34 from services provided under this section.

45.1 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
45.2 and the recipient's institutional care is paid by medical assistance, payment for targeted case
45.3 management services under this subdivision is limited to the lesser of:

45.4 (1) the last 180 days of the recipient's residency in that facility; or

45.5 (2) the limits and conditions which apply to federal Medicaid funding for this service.

45.6 (k) Payment for targeted case management services under this subdivision shall not
45.7 duplicate payments made under other program authorities for the same purpose.

45.8 (l) Any growth in targeted case management services and cost increases under this
45.9 section shall be the responsibility of the counties or Tribes.

45.10 (m) The commissioner may make payments for Tribes according to section 256B.0625,
45.11 subdivision 34, or other relevant federally approved rate setting methodologies for vulnerable
45.12 adult and developmental disability targeted case management provided by Indian health
45.13 services and facilities operated by a Tribe or Tribal organization.

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

45.16 Sec. 30. Minnesota Statutes 2024, section 256B.0924, subdivision 7, is amended to read:

45.17 Subd. 7. **Implementation and evaluation.** The commissioner of human services in
45.18 consultation with county boards and Tribal Nations shall establish a program to accomplish
45.19 the provisions of subdivisions 1 to 6. The commissioner in consultation with county boards
45.20 and Tribal Nations shall establish performance measures to evaluate the effectiveness of
45.21 the targeted case management services. If a county or Tribe fails to meet agreed-upon
45.22 performance measures, the commissioner may authorize contracted providers other than
45.23 the county or Tribe. Providers contracted by the commissioner shall also be subject to the
45.24 standards in subdivision 6.

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

45.26 Sec. 31. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 2, is
45.27 amended to read:

45.28 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this
45.29 subdivision.

45.30 (b) "Advanced certification" means a person who has completed advanced certification
45.31 in an approved modality under subdivision 13, paragraph (b).

46.1 (c) "Agency" means the legal entity that is enrolled with Minnesota health care programs
46.2 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide
46.3 EIDBI services and that has the legal responsibility to ensure that its employees carry out
46.4 the responsibilities defined in this section. Agency includes a licensed individual professional
46.5 who practices independently and acts as an agency.

46.6 (d) "Autism spectrum disorder or a related condition" or "ASD or a related condition"
46.7 means either autism spectrum disorder (ASD) as defined in the current version of the
46.8 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found
46.9 to be closely related to ASD, as identified under the current version of the DSM, and meets
46.10 all of the following criteria:

46.11 (1) is severe and chronic;

46.12 (2) results in impairment of adaptive behavior and function similar to that of a person
46.13 with ASD;

46.14 (3) requires treatment or services similar to those required for a person with ASD; and

46.15 (4) results in substantial functional limitations in three core developmental deficits of
46.16 ASD: social or interpersonal interaction; functional communication, including nonverbal
46.17 or social communication; and restrictive or repetitive behaviors or hyperreactivity or
46.18 hyporeactivity to sensory input; and may include deficits or a high level of support in one
46.19 or more of the following domains:

46.20 (i) behavioral challenges and self-regulation;

46.21 (ii) cognition;

46.22 (iii) learning and play;

46.23 (iv) self-care; or

46.24 (v) safety.

46.25 (e) "Behavior analyst" means an individual licensed under sections 148.9981 to 148.9995
46.26 as a behavior analyst.

46.27 (f) "Clinical supervision" means the overall responsibility for the control and direction
46.28 of EIDBI service delivery, including ~~individual treatment planning~~, staff supervision,
46.29 including observation and direction; individual treatment plan development and progress
46.30 monitoring; family training and counseling; and treatment review coordinated care
46.31 conference coordination for each person. Clinical supervision is provided by a qualified

47.1 supervising professional (QSP) who takes full professional responsibility for the service
47.2 provided by each supervisee and the clinical effectiveness of all interventions.

47.3 (g) "Commissioner" means the commissioner of human services, unless otherwise
47.4 specified.

47.5 (h) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
47.6 evaluation of a person to determine medical necessity for EIDBI services based on the
47.7 requirements in subdivision 5.

47.8 (i) "Department" means the Department of Human Services, unless otherwise specified.

47.9 (j) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
47.10 benefit" means a variety of individualized, intensive treatment modalities approved and
47.11 published by the commissioner that are based in behavioral and developmental science
47.12 consistent with best practices on effectiveness.

47.13 (k) "Employee of an agency" or "employee" means any individual who is employed
47.14 temporarily, part time, or full time by the agency that is submitting claims or billing for the
47.15 work, services, supervision, or treatment performed by the individual. Employee does not
47.16 include an independent contractor, billing agency, or consultant who is not providing EIDBI
47.17 services. Employee does not include an individual who performs work, provides services,
47.18 supervises, or provides treatment for less than 80 hours in a 12-month period.

47.19 (l) "Generalizable goals" means results or gains that are observed during a variety of
47.20 activities over time with different people, such as providers, family members, other adults,
47.21 and people, and in different environments including, but not limited to, clinics, homes,
47.22 schools, and the community.

47.23 (m) "Incident" means when any of the following occur:

47.24 (1) an illness, accident, or injury that requires first aid treatment;

47.25 (2) a bump or blow to the head; or

47.26 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,
47.27 including a person leaving the agency unattended.

47.28 (n) "Individual treatment plan" or "ITP" means the person-centered, individualized
47.29 written plan of care that integrates and coordinates person and family information from the
47.30 CMDE for a person who meets medical necessity for the EIDBI benefit. An individual
47.31 treatment plan must meet the standards in subdivision 6.

48.1 (o) "Legal representative" means the parent of a child who is under 18 years of age, a
48.2 court-appointed guardian, or other representative with legal authority to make decisions
48.3 about service for a person. For the purpose of this subdivision, "other representative with
48.4 legal authority to make decisions" includes a health care agent or an attorney-in-fact
48.5 authorized through a health care directive or power of attorney.

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

48.8 (q) "Person" means an individual under 21 years of age.

48.9 (r) "Person-centered" means a service that both responds to the identified needs, interests,
48.10 values, preferences, and desired outcomes of the person or the person's legal representative
48.11 and respects the person's history, dignity, and cultural background and allows inclusion and
48.12 participation in the person's community.

48.13 (s) "Qualified EIDBI provider" means an individual who is a QSP or a level I, level II,
48.14 or level III treatment provider.

48.15 Sec. 32. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
48.16 amended to read:

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

48.19 (1) enroll as a medical assistance Minnesota health care program provider according to
48.20 Minnesota Rules, part 9505.0195, and section 256B.04, subdivision 21, and meet all
48.21 applicable provider standards and requirements;

48.22 (2) designate an individual as the agency's compliance officer who must perform the
48.23 duties described in section 256B.04, subdivision 21, paragraph (g);

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

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

48.28 (5) demonstrate that while enrolled or seeking enrollment as a Minnesota health care
48.29 program provider the agency did not have a lead agency contract or provider agreement
48.30 discontinued because of a conviction of fraud; or did not have an owner, board member, or
48.31 manager fail a state or federal criminal background check or appear on the list of excluded

49.1 individuals or entities maintained by the federal Department of Human Services Office of
49.2 Inspector General;

49.3 (6) have established business practices including written policies and procedures, internal
49.4 controls, and a system that demonstrates the organization's ability to deliver quality EIDBI
49.5 services, appropriately submit claims, conduct required staff training, document staff
49.6 qualifications, document service activities, and document service quality;

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

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

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

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

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

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

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

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

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

49.30 (16) provide the required EIDBI intervention observation and direction by a QSP or
49.31 Level I provider at least once per month. Notwithstanding subdivision 13, paragraph (l),
49.32 required EIDBI intervention observation and direction under this clause may be conducted

50.1 via telehealth provided that no more than two consecutive monthly required EIDBI
 50.2 intervention observation and direction sessions under this clause are conducted via telehealth.

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

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

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

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

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

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

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

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

50.21 Sec. 33. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision
 50.22 to read:

50.23 Subd. 19. **Documentation requirements.** (a) CMDE and EIDBI providers must ensure
 50.24 that all documentation, including but not limited to health service records and personnel
 50.25 files, complies with this subdivision, subdivision 16, and Minnesota Rules, parts 9505.2175
 50.26 and 9505.2197. Documentation must be complete, legible, accurate, and readily accessible.

50.27 (b) All documentation must:

50.28 (1) be legible and understandable to individuals outside service delivery;

50.29 (2) include the participant's name on each health record page and the provider's name
 50.30 on each personnel file page;

- 51.1 (3) be signed and dated by the provider completing the documentation, with the provider's
 51.2 full name, title, and credentials;
- 51.3 (4) be entered within 72 hours of service, and contain a record and explanation of any
 51.4 delays in entry;
- 51.5 (5) clearly reflect clinical decision-making and support medical necessity;
- 51.6 (6) be securely stored in accordance with the Health Insurance Portability and
 51.7 Accountability Act (HIPAA), Public Law 104-191;
- 51.8 (7) be stored in accordance with state and federal document retention laws;
- 51.9 (8) be available for review or audit;
- 51.10 (9) include a record of caregiver involvement where applicable; and
- 51.11 (10) include a record of supervision and oversight for staff providing services requiring
 51.12 supervision under EIDBI policy.
- 51.13 (c) Each EIDBI service occurrence must be documented in a progress note in a manner
 51.14 and with the information determined by the commissioner.
- 51.15 (d) All providers must maintain current personnel records for each employee in a manner
 51.16 determined by the commissioner that include:
- 51.17 (1) the employee's name, contact information, and hire date;
- 51.18 (2) the employee's completed employment application and acknowledgment of duties;
- 51.19 (3) the job description for the employee's job with the effective date;
- 51.20 (4) verification of the employee's qualifications, including but not limited to education,
 51.21 licenses, certifications, enrollment attestation, degrees, transcripts, and experience;
- 51.22 (5) a background check pursuant to chapter 245C;
- 51.23 (6) orientation and required training the employee attended, including but not limited
 51.24 to training on mandated reporting, cultural responsiveness, and EIDBI competencies;
- 51.25 (7) the dates of the employee's first supervised and unsupervised client contact following
 51.26 employment;
- 51.27 (8) documentation of supervision received by the employee, including but not limited
 51.28 to the supervisor's name and credentials, dates of supervision, and supervision content;
- 51.29 (9) the employee's CPR and emergency response training, if required; and
- 51.30 (10) the employee's annual performance evaluations.

52.1 Sec. 34. Minnesota Statutes 2024, section 256B.4905, subdivision 2a, is amended to read:

52.2 Subd. 2a. **Informed choice policy.** (a) It is the policy of this state that all adults who
52.3 have disabilities and, with support from their families or legal representatives, that all
52.4 children who have disabilities:

52.5 (1) may make informed choices to select and utilize disability services and supports;
52.6 and

52.7 (2) are offered an informed decision-making process sufficient to make informed choices.

52.8 (b) It is the policy of this state that disability waivers services support the presumption
52.9 that adults who have disabilities and, with support from their families or legal representatives,
52.10 all children who have disabilities may make informed choices; and that all adults who have
52.11 disabilities and all families of children who have disabilities and are accessing waiver
52.12 services under sections 256B.092 and 256B.49 are provided an informed decision-making
52.13 process that satisfies the requirements of subdivision 3a.

52.14 (c) Lead agencies must support individuals in making informed choices by:

52.15 (1) providing complete and accurate information about available home and
52.16 community-based services and settings;

52.17 (2) providing the information in a manner that is culturally and linguistically appropriate;
52.18 and

52.19 (3) facilitating access to services that reflect the individual's preferences and assessed
52.20 needs.

52.21 (d) For individuals who are members of or affiliated with a federally recognized Tribal
52.22 Nation located within Minnesota, informed choice includes the right to receive services
52.23 administered or provided by the individual's Tribal Nation. Lead agencies must:

52.24 (1) inform individuals of services offered by Tribal Nations enrolled as Minnesota health
52.25 care providers;

52.26 (2) directly coordinate with the individual's Tribal Nation human services agency when
52.27 the individual seeks or may be eligible for services administered or provided by that Tribal
52.28 Nation; and

52.29 (3) ensure that service planning and delivery respects the individual's rights as both a
52.30 member of a sovereign Tribal Nation and a resident of Minnesota.

53.1 (e) County lead agencies and Tribal Nation human services agencies must establish and
 53.2 maintain procedures to share updated contact information, coordinate case management,
 53.3 and provide timely referrals necessary to ensure that informed choice is fully exercised.

53.4 (f) Nothing in this section limits the sovereignty of Tribal Nations or the authority of
 53.5 Tribal governments to administer home and community-based services to their members.

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

53.7 Sec. 35. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 8, is
 53.8 amended to read:

53.9 Subd. 8. **Unit-based services with programming; component values and calculation**
 53.10 **of payment rates.** (a) For the purpose of this section, unit-based services with programming
 53.11 include employment exploration services, employment development services, employment
 53.12 support services, individualized home supports with family training, individualized home
 53.13 supports with training, and positive support services provided to an individual outside of
 53.14 any service plan for a day program or residential support service.

53.15 (b) Component values for unit-based services with programming are:

53.16 (1) competitive workforce factor: 6.7 percent;

53.17 (2) supervisory span of control ratio: 11 percent;

53.18 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

53.19 (4) employee-related cost ratio: 23.6 percent;

53.20 (5) program plan support ratio: 15.5 percent;

53.21 (6) client programming and support ratio: 4.7 percent, updated as specified in subdivision
 53.22 5b;

53.23 (7) general administrative support ratio: 13.25 percent;

53.24 (8) program-related expense ratio: 6.1 percent; and

53.25 (9) absence and utilization factor ratio: 3.9 percent.

53.26 (c) A unit of service for unit-based services with programming is 15 minutes.

53.27 (d) Payments for unit-based services with programming must be calculated as follows,
 53.28 unless the services are reimbursed separately as part of a residential support services or day
 53.29 program payment rate:

53.30 (1) determine the number of units of service to meet a recipient's needs;

54.1 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
54.2 provided in subdivisions 5 and 5a;

54.3 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
54.4 product of one plus the competitive workforce factor;

54.5 (4) for a recipient requiring customization for deaf and hard-of-hearing language
54.6 accessibility under subdivision 12, add the customization rate provided in subdivision 12
54.7 to the result of clause (3);

54.8 (5) multiply the number of direct staffing hours by the appropriate staff wage;

54.9 (6) multiply the number of direct staffing hours by the product of the supervisory span
54.10 of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

54.11 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
54.12 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
54.13 rate;

54.14 (8) for program plan support, multiply the result of clause (7) by one plus the program
54.15 plan support ratio;

54.16 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
54.17 employee-related cost ratio;

54.18 (10) for client programming and supports, multiply the result of clause (9) by one plus
54.19 the client programming and support ratio;

54.20 (11) this is the subtotal rate;

54.21 (12) sum the standard general administrative support ratio, the program-related expense
54.22 ratio, and the absence and utilization factor ratio;

54.23 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
54.24 total payment amount;

54.25 (14) for services provided in a shared manner, divide the total payment in clause (13)
54.26 as follows:

54.27 (i) for employment exploration services, divide by the number of service recipients, not
54.28 to exceed five;

54.29 (ii) for employment support services, divide by the number of service recipients, not to
54.30 exceed six;

55.1 (iii) for individualized home supports with training and individualized home supports
55.2 with family training, divide by the number of service recipients, not to exceed three; and

55.3 (iv) for night supervision, divide by the number of service recipients, not to exceed two;
55.4 and

55.5 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
55.6 to adjust for regional differences in the cost of providing services.

55.7 (e) Effective January 1, 2026, or upon federal approval, whichever is later, a provider
55.8 must not bill more than three consecutive hours and not more than six total hours per day
55.9 for individualized home supports with training and individualized home supports with family
55.10 training. This daily limit does not limit a person's use of other disability waiver services,
55.11 including individualized home supports, which may be provided on the same day by the
55.12 same provider providing individualized home supports with training or individualized home
55.13 supports with family training. This paragraph expires upon the effective date of paragraph
55.14 (f).

55.15 (f) Effective January 1, 2027, or upon federal approval, whichever is later, a provider
55.16 must not bill more than:

55.17 (1) for individualized home supports with training, a monthly unit of service determined
55.18 by multiplying 24 units by the total number of days in the month during which service was
55.19 provided; and

55.20 (2) for individualized home supports with family training, not more than six total hours
55.21 per day.

55.22 Sec. 36. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 10a, is
55.23 amended to read:

55.24 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
55.25 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
55.26 service. As determined by the commissioner, in consultation with community partners
55.27 identified in subdivision 17, a provider enrolled to provide services with rates determined
55.28 under this section must submit requested cost data to the commissioner to support research
55.29 on the cost of providing services that have rates determined by the disability waiver rates
55.30 system. Requested cost data may include, but is not limited to:

55.31 (1) worker wage costs;

55.32 (2) benefits paid;

- 56.1 (3) supervisor wage costs;
- 56.2 (4) executive wage costs;
- 56.3 (5) vacation, sick, and training time paid;
- 56.4 (6) taxes, workers' compensation, and unemployment insurance costs paid;
- 56.5 (7) administrative costs paid;
- 56.6 (8) program costs paid;
- 56.7 (9) transportation costs paid;
- 56.8 (10) vacancy rates; and
- 56.9 (11) other data relating to costs required to provide services requested by the
- 56.10 commissioner.

56.11 (b) At least once in any five-year period, a provider must submit cost data for a fiscal

56.12 year that ended not more than 18 months prior to the submission date. The commissioner

56.13 shall provide each provider a 90-day notice prior to its submission due date. The

56.14 commissioner may review report submissions for inaccurate, inconclusive, incomplete, or

56.15 otherwise deficient data and may remove the report from submitted status for further

56.16 verification. If a provider fails to submit required reporting data, the commissioner shall

56.17 provide notice to providers that have not provided required data 30 days after the required

56.18 submission date, and a second notice for providers who have not provided required data 60

56.19 days after the required submission date. The commissioner shall temporarily suspend

56.20 payments to the provider if cost data is not received 90 days after the required submission

56.21 date. Withheld payments shall be made once data is received and reviewed for compliance

56.22 by the commissioner.

56.23 (c) The commissioner shall conduct a random validation of data submitted under

56.24 paragraph (a) to ensure data accuracy. Providers selected to validate cost reports must

56.25 respond to the commissioner within 30 days with the requested financial documentation. If

56.26 a provider fails to respond to the commissioner with all the requested information within

56.27 30 days, the commissioner must temporarily suspend payments. The commissioner must

56.28 resume payments once the requested documentation is received. If a provider is unable to

56.29 validate the provider's costs with supporting documentation, the commissioner must require

56.30 the provider to participate in the random validation the next year that the commissioner

56.31 selects providers to report their costs. The commissioner shall analyze cost documentation

56.32 in paragraph (a) and provide recommendations for adjustments to cost components.

57.1 (d) The commissioner shall analyze cost data submitted under paragraph (a). The
 57.2 commissioner shall release cost data in an aggregate form. Cost data from individual
 57.3 providers must not be released except as provided for in current law.

57.4 (e) Beginning January 1, 2029, the commissioner shall use data collected in paragraph
 57.5 (a) to determine the compliance with requirements identified under subdivision 10d. The
 57.6 commissioner shall identify providers who have not met the thresholds identified under
 57.7 subdivision 10d on the Department of Human Services website for the year for which the
 57.8 providers reported their costs.

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

57.10 Sec. 37. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 7, is amended
 57.11 to read:

57.12 Subd. 7. **Community first services and supports; covered services.** Services and
 57.13 supports covered under CFSS include:

57.14 (1) assistance to accomplish activities of daily living (ADLs), instrumental activities of
 57.15 daily living (IADLs), and health-related procedures and tasks through hands-on assistance
 57.16 to accomplish the task or constant supervision and cueing to accomplish the task;

57.17 (2) assistance to acquire, maintain, or enhance the skills necessary for the participant to
 57.18 accomplish activities of daily living, instrumental activities of daily living, or health-related
 57.19 tasks;

57.20 (3) expenditures for items, services, supports, environmental modifications, or goods,
 57.21 including assistive technology. These expenditures must:

57.22 (i) relate to a need identified in a participant's CFSS service delivery plan; and

57.23 (ii) increase independence or substitute for human assistance, to the extent that
 57.24 expenditures would otherwise be made for human assistance for the participant's assessed
 57.25 needs;

57.26 (4) observation and redirection for behavior or symptoms where there is a need for
 57.27 assistance;

57.28 (5) back-up systems or mechanisms, such as the use of pagers or other electronic devices,
 57.29 to ensure continuity of the participant's services and supports;

57.30 (6) swimming lessons for a participant younger than 12 years of age whose disability
 57.31 puts the participant at a higher risk of drowning according to the Centers for Disease Control
 57.32 Vital Statistics System;

58.1 (7) services described under subdivision 17 provided by a consultation services provider
58.2 meeting the requirements of subdivision 17a;

58.3 (8) services provided by an FMS provider as defined under subdivision 13a; that is an
58.4 enrolled provider with the department;

58.5 (9) CFSS services provided by a support worker who is a parent, stepparent, or legal
58.6 guardian of a participant under age 18, or who is the participant's spouse. Covered services
58.7 under this clause are subject to the limitations described in subdivision 7b; ~~and~~

58.8 (10) shared services meeting the shared service requirements of this section; and

58.9 ~~(10)~~ (11) worker training and development services as described in subdivision 18a.

58.10 Sec. 38. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision
58.11 to read:

58.12 Subd. 7c. **Shared services under the agency-provider model.** (a) The commissioner
58.13 shall authorize shared service arrangements if the commissioner determines that a shared
58.14 service arrangement is appropriate to meet all the participants' needs and sufficient to
58.15 maintain the participants' health and safety. The commissioner must include a decision
58.16 regarding authorization of shared services during the process of authorizing CFSS under
58.17 subdivision 8. The commissioner must not reduce the total number of authorized units for
58.18 a participant who elects to receive shared services.

58.19 (b) An agency-provider must offer a participant or the participant's representative the
58.20 option of shared services, one-on-one services, or a combination of both shared services
58.21 and one-on-one services when shared services are authorized by the commissioner. The
58.22 option of shared services may be elected at the sole discretion of either the participant or
58.23 the participant's representative. The participant or the participant's representative may
58.24 withdraw from participating in a shared service arrangement at any time.

58.25 Sec. 39. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision
58.26 to read:

58.27 Subd. 7d. **Shared service rates under the agency-provider model.** The commissioner
58.28 shall provide a rate system for shared services. For two participants sharing services, the
58.29 rate paid to an agency-provider for the shared services must not exceed one and one-half
58.30 times the rate paid for serving a single participant. For three participants sharing services,
58.31 the rate paid to an agency-provider for the shared services must not exceed twice the rate

59.1 paid for serving a single participant. These rates apply only when all criteria for shared
59.2 services are met.

59.3 Sec. 40. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision
59.4 to read:

59.5 Subd. 7e. **Pass-through for shared services under the agency-provider model.** (a)
59.6 Of the additional revenue for shared services provided to two participants, the
59.7 agency-provider must use 95 percent for the purposes specified in paragraph (b). Of the
59.8 additional revenue for shared services provided to three participants, the agency-provider
59.9 must use 95 percent for the purposes specified in paragraph (b).

59.10 (b) An agency-provider must use the percentages of additional revenue for shared services
59.11 specified in paragraph (a) for the wages and wage-related costs of the support worker
59.12 providing the shared services. The agency-provider must not use additional revenue for
59.13 shared services to pay for mileage reimbursements, uniform allowances, health and dental
59.14 insurance, life insurance, disability insurance, long-term care insurance, contributions to
59.15 employee retirement accounts when the contribution is not a function of wages, or any other
59.16 employee benefits.

59.17 Sec. 41. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision
59.18 to read:

59.19 Subd. 7f. **Shared services under the budget model.** (a) A participant who intends to
59.20 elect shared services under the budget model, or the participant's representative, must include
59.21 a statement of this intention in the CFSS service delivery plan, must develop a plan for
59.22 shared services when developing or amending the CFSS service delivery plan, and must
59.23 follow the CFSS process for approval of the plan as required under subdivision 6.

59.24 (b) The commissioner shall authorize shared service arrangements if the commissioner
59.25 determines that a shared service arrangement is appropriate to meet all the participants'
59.26 needs and sufficient to maintain the participants' health and safety. The commissioner must
59.27 include a decision regarding authorization of shared services during the process of authorizing
59.28 CFSS under subdivision 8. The commissioner must not reduce the total authorized dollar
59.29 amount available to a participant who elects to receive shared services.

59.30 (c) The participants, or participants' representatives as needed, who elect to share services
59.31 under the budget model must jointly develop a shared service agreement with the support
59.32 of the participants' representatives as needed. Any participant or any participant's
59.33 representative may at any time withdraw from participating in a shared service agreement.

60.1 (d) The commissioner must develop and publish recommendations for negotiating wages
 60.2 for support workers providing shared services under the budget model.

60.3 Sec. 42. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision
 60.4 to read:

60.5 Subd. 7g. **Pass-through for shared services under the budget model.** (a) Of the budget
 60.6 savings for shared services provided to two participants, the participant employer must use
 60.7 95 percent for the purposes specified in paragraph (b). Of the budget savings for shared
 60.8 services provided to three participants, the participant provider must use 95 percent for the
 60.9 purposes specified in paragraph (b).

60.10 (b) A participant employer must use the percentages of budget savings for shared services
 60.11 specified in paragraph (a) for the wages and wage-related costs of the support worker
 60.12 providing the shared services. The participant employer must not use budget savings for
 60.13 shared services to pay for mileage reimbursements, uniform allowances, health and dental
 60.14 insurance, life insurance, disability insurance, long-term care insurance, contributions to
 60.15 employee retirement accounts when the contribution is not a function of wages, or any other
 60.16 employee benefits.

60.17 Sec. 43. [256B.8502] COMMUNITY FIRST SERVICES AND SUPPORTS;
 60.18 DEFINITIONS.

60.19 Subdivision 1. **Scope.** For the purposes of this section and sections 256B.85 and
 60.20 256B.851, the terms in this section have the meanings given.

60.21 Subd. 2. **Additional revenue for shared services.** "Additional revenue for shared
 60.22 services" means the difference between the rate paid to an agency-provider for serving a
 60.23 single participant and the sum of the rates paid to a personal care assistance provider agency
 60.24 for shared services provided to more than one recipient.

60.25 Subd. 3. **Budget savings for shared services.** "Budget savings for shared services"
 60.26 means the difference between the wages and wage-related costs paid by a participant
 60.27 employer to a support worker providing one-on-one service to the participant employer and:

60.28 (1) for two-to-one shared services, three-quarters of the wages and wage-related costs
 60.29 paid by a participant employer to a support worker providing one-on-one service; or

60.30 (2) for three-to-one shared services, two-thirds of the wages and wage-related costs paid
 60.31 by a participant employer to a support worker providing one-on-one service.

61.1 Subd. 4. **Wages and wage-related costs.** "Wages and wage-related costs" means
 61.2 increased wages and any corresponding increase in the employer's or participant employer's
 61.3 share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers'
 61.4 compensation premiums, and contributions to employee retirement accounts when the
 61.5 contribution is a function of wages.

61.6 Sec. 44. Minnesota Statutes 2024, section 256B.851, subdivision 8, is amended to read:

61.7 **Subd. 8. Personal care provider agency; required reporting of cost data; training.** (a)
 61.8 As determined by the commissioner and in consultation with stakeholders, agencies enrolled
 61.9 to provide services with rates determined under this section must submit requested cost data
 61.10 to the commissioner. The commissioner may request cost data, including but not limited
 61.11 to:

61.12 (1) worker wage costs;

61.13 (2) benefits paid;

61.14 (3) supervisor wage costs;

61.15 (4) executive wage costs;

61.16 (5) vacation, sick, and training time paid;

61.17 (6) taxes, workers' compensation, and unemployment insurance costs paid;

61.18 (7) administrative costs paid;

61.19 (8) program costs paid;

61.20 (9) transportation costs paid;

61.21 (10) staff vacancy rates; and

61.22 (11) other data relating to costs required to provide services requested by the
 61.23 commissioner.

61.24 (b) At least once in any three-year period, a provider must submit the required cost data
 61.25 for a fiscal year that ended not more than 18 months prior to the submission date. The
 61.26 commissioner must provide each provider a 90-day notice prior to its submission due date.
 61.27 The commissioner may review report submissions for inaccurate, inconclusive, incomplete,
 61.28 or otherwise deficient data and may remove the report from submitted status for further
 61.29 verification. If a provider fails to submit required cost data, the commissioner must provide
 61.30 notice to a provider that has not provided required cost data 30 days after the required
 61.31 submission date and a second notice to a provider that has not provided required cost data

62.1 60 days after the required submission date. The commissioner must temporarily suspend
 62.2 payments to a provider if the commissioner has not received required cost data 90 days after
 62.3 the required submission date. The commissioner must make withheld payments when the
 62.4 required cost data is received and reviewed for compliance by the commissioner.

62.5 (c) The commissioner must conduct a random validation of data submitted under this
 62.6 subdivision to ensure data accuracy. A provider selected to validate the provider's cost
 62.7 reports must respond to the commissioner within 30 days with the requested financial
 62.8 documentation. If a provider fails to respond to the commissioner with the requested
 62.9 information within 30 days, the commissioner must temporarily suspend payments. The
 62.10 commissioner must resume payments once the requested documentation is received. If a
 62.11 provider is unable to validate the provider's costs with supporting documentation, the
 62.12 commissioner must require the provider to participate in the random validation the next
 62.13 year that the commissioner selects providers to report their costs. The commissioner shall
 62.14 analyze cost documentation in paragraph (a) and provide recommendations for adjustments
 62.15 to cost components.

62.16 (d) The commissioner, in consultation with stakeholders, must develop and implement
 62.17 a process for providing training and technical assistance necessary to support provider
 62.18 submission of cost data required under this subdivision.

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

62.20 Sec. 45. Minnesota Statutes 2024, section 256L.03, subdivision 1, is amended to read:

62.21 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
 62.22 services reimbursed under chapter 256B, with the exception of special education services,
 62.23 home care nursing services, nonemergency medical transportation services, personal care
 62.24 assistance and case management services, community first services and supports under
 62.25 section 256B.85, behavioral health home services under section 256B.0757, ~~housing~~
 62.26 ~~stabilization services under section 256B.051,~~ and nursing home or intermediate care facilities
 62.27 services.

62.28 (b) Covered health services shall be expanded as provided in this section.

62.29 (c) For the purposes of covered health services under this section, "child" means an
 62.30 individual younger than 19 years of age.

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

63.1 Sec. 46. Minnesota Statutes 2024, section 256R.481, is amended to read:

63.2 **256R.481 RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.**

63.3 (a) The commissioner shall allow each nonprofit nursing facility located within the
63.4 boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once
63.5 annually for a rate add-on to the facility's external fixed costs payment rate.

63.6 (b) A facility seeking an add-on to its external fixed costs payment rate under this section
63.7 must apply annually to the commissioner to receive the add-on. A facility must submit the
63.8 application within 60 calendar days of the effective date of any add-on under this section.
63.9 The commissioner may waive the deadlines required by this paragraph under extraordinary
63.10 circumstances.

63.11 (c) The commissioner shall provide the add-on to each eligible facility that applies by
63.12 the application deadline.

63.13 (d) The add-on to the external fixed costs payment rate is the difference on January 1
63.14 of the median total payment rate for ~~ease-mix classification PA+~~ the lowest case mix
63.15 classification in effect of the nonprofit facilities located in an adjacent city in another state
63.16 and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment
63.17 rate for ~~ease-mix classification PA+~~ the lowest case mix classification in effect as determined
63.18 under section 256R.22, subdivision 4.

63.19 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2026, and
63.20 applies to rate years beginning on or after January 1, 2026.

63.21 Sec. 47. Minnesota Statutes 2024, section 256S.205, subdivision 1, is amended to read:

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

63.24 (b) "Application year" means a year in which a facility submits an application for
63.25 designation as a disproportionate share facility.

63.26 (c) "Customized living resident" means a resident of a facility who is receiving either
63.27 24-hour customized living services or customized living services authorized under the
63.28 elderly waiver, the brain injury waiver, or the community access for disability inclusion
63.29 waiver. Effective August 31, 2026, a resident who experiences an interruption to waiver
63.30 benefits resulting from a temporary absence from the facility is a customized living resident
63.31 during the period of the temporary absence for purposes of this section.

64.1 (d) "Disproportionate share facility" means a facility designated by the commissioner
64.2 under subdivision 4.

64.3 (e) "Facility" means either an assisted living facility licensed under chapter 144G or a
64.4 setting that is exempt from assisted living licensure under section 144G.08, subdivision 7,
64.5 clauses (10) to (13).

64.6 (f) "Rate year" means January 1 to December 31 of the year following an application
64.7 year.

64.8 (g) "Residing in the facility" means that the facility is the resident's fixed permanent
64.9 home and the place to which the resident intends to return following a temporary absence.

64.10 Sec. 48. Minnesota Statutes 2025 Supplement, section 256S.205, subdivision 2, is amended
64.11 to read:

64.12 Subd. 2. **Rate adjustment application.** (a) Effective through September 30, 2023, a
64.13 facility may apply to the commissioner for an initial designation as a disproportionate share
64.14 facility. Applications must be submitted annually between September 1 and September 30.
64.15 The applying facility must apply in a manner determined by the commissioner. The applying
64.16 facility must document each of the following on the application:

64.17 (1) the number of customized living residents residing in the facility on September 1 of
64.18 the application year, broken out by specific waiver program; and

64.19 (2) the total number of people residing in the facility on September 1 of the application
64.20 year.

64.21 (b) Effective October 1, 2023, the commissioner must not process any new initial
64.22 applications for disproportionate share facilities.

64.23 (c) A facility that received rate floor payments in rate year 2024 may submit an annual
64.24 application under this subdivision to maintain its designation as a disproportionate share
64.25 facility.

64.26 Sec. 49. Minnesota Statutes 2024, section 256S.21, subdivision 3, is amended to read:

64.27 Subd. 3. **Cost reporting.** (a) As determined by the commissioner, in consultation with
64.28 stakeholders, a provider enrolled to provide services with rates determined under this chapter
64.29 must submit requested cost data to the commissioner to support evaluation of the rate
64.30 methodologies in this chapter. Requested cost data may include but are not limited to:

64.31 (1) worker wage costs;

- 65.1 (2) benefits paid;
- 65.2 (3) supervisor wage costs;
- 65.3 (4) executive wage costs;
- 65.4 (5) vacation, sick, and training time paid;
- 65.5 (6) taxes, workers' compensation, and unemployment insurance costs paid;
- 65.6 (7) administrative costs paid;
- 65.7 (8) program costs paid;
- 65.8 (9) transportation costs paid;
- 65.9 (10) vacancy rates; and
- 65.10 (11) other data relating to costs required to provide services requested by the
- 65.11 commissioner.

65.12 (b) At least once in any five-year period, a provider must submit the required cost data

65.13 for a fiscal year that ended not more than 18 months prior to the submission date. The

65.14 commissioner ~~shall~~ must provide each provider a 90-day notice prior to the provider's

65.15 submission due date. The commissioner may review report submissions for inaccurate,

65.16 inconclusive, incomplete, or otherwise deficient data and may remove the report from

65.17 submitted status for further verification. If by 30 days after the required submission date a

65.18 provider fails to submit required reporting data, the commissioner ~~shall~~ must provide notice

65.19 to the provider; ~~and~~. If by 60 days after the required submission date a provider has not

65.20 provided the required data, the commissioner ~~shall~~ must provide a second notice. The

65.21 commissioner ~~shall~~ must temporarily suspend payments to ~~the~~ a provider if the commissioner

65.22 has not received the required cost data is not received 90 days after the required submission

65.23 date or 90 days after the Department of Human Services requests updated data. The

65.24 commissioner must make withheld payments must be made once data is received when the

65.25 required cost data is received and reviewed for compliance by the commissioner.

65.26 (c) The commissioner shall coordinate the cost reporting activities required under this

65.27 section with the cost reporting activities directed under section 256B.4914, subdivision 10a.

65.28 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in

65.29 consultation with stakeholders, may submit recommendations on rate methodologies in this

65.30 chapter, including ways to monitor and enforce the spending requirements directed in section

65.31 ~~256S.2101, subdivision 3,~~ 256S.211, subdivision 4, through the reports directed by

65.32 subdivision 2.

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

66.2 Sec. 50. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
66.3 to read:

66.4 **Subd. 1a. Adult protective services.** Adult protective services must receive referrals
66.5 from the common entry point and carry out lead investigative agency duties to investigate
66.6 for a determination of responsibility for maltreatment. When the county social services
66.7 agency is the lead investigative agency, or when the Department of Human Services or
66.8 Department of Health in the role of the lead investigative agency request adult protective
66.9 services, adult protective services must conduct assessments, develop services plans, and
66.10 implement interventions to safeguard adults who are vulnerable and suspected of experiencing
66.11 maltreatment. Adult protective services must conclude services following final determination
66.12 of maltreatment and the adult is assessed as safe. The Department of Human Services is the
66.13 state agency responsible for supervision of adult protective services administered by county
66.14 social services agencies.

66.15 Sec. 51. Minnesota Statutes 2024, section 626.557, subdivision 9, is amended to read:

66.16 **Subd. 9. Common entry point designation.** (a) The commissioner of human services
66.17 shall establish a common entry point. The common entry point is the unit responsible for
66.18 receiving the report of suspected maltreatment under this section.

66.19 (b) The common entry point must be available 24 hours per day to ~~take calls~~ accept
66.20 reports from reporters of suspected maltreatment and make required referrals for suspected
66.21 maltreatment of a vulnerable adult. The common entry point shall use a standard intake
66.22 form that includes:

66.23 (1) the time and date of the report;

66.24 (2) the name, relationship, and identifying and contact information for the person believed
66.25 to be a vulnerable adult and the individual or facility alleged responsible for maltreatment;

66.26 (3) the name, relationship, and contact information for the:

66.27 (i) reporter;

66.28 (ii) initial reporter, witnesses, and persons who may have knowledge about the
66.29 maltreatment; and

66.30 (iii) legal surrogate and persons who may provide support to the vulnerable adult;

66.31 (4) the basis of vulnerability for the vulnerable adult;

- 67.1 (5) the time, date, and location of the incident;
- 67.2 (6) the immediate safety risk to the vulnerable adult;
- 67.3 (7) a description of the suspected maltreatment;
- 67.4 (8) the impact of the suspected maltreatment on the vulnerable adult;
- 67.5 (9) whether a facility was involved and, if so, which agency licenses the facility;
- 67.6 (10) the actions taken to protect the vulnerable adult;
- 67.7 (11) the required notifications and referrals made by the common entry point; and
- 67.8 (12) whether the reporter wishes to receive notification of the disposition.
- 67.9 (c) The common entry point is not required to complete each item on the form prior to
67.10 dispatching the report to the appropriate lead investigative agency.
- 67.11 (d) The common entry point shall immediately report to a law enforcement agency any
67.12 incident in which there is reason to believe a crime has been committed.
- 67.13 (e) If a report is initially made to a law enforcement agency or a lead investigative agency,
67.14 those agencies shall take the report on the appropriate common entry point intake forms
67.15 and immediately forward a copy to the common entry point.
- 67.16 (f) The common entry point staff must receive training on how to screen and dispatch
67.17 reports efficiently and in accordance with this section.
- 67.18 (g) The commissioner of human services shall maintain a centralized database for the
67.19 collection of common entry point data, lead investigative agency data including maltreatment
67.20 report disposition, and appeals data. The common entry point shall have access to the
67.21 centralized database and must log the reports into the database.
- 67.22 (h) When appropriate, the common entry point staff must refer calls that do not allege
67.23 the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might
67.24 resolve the reporter's concerns.
- 67.25 (i) A common entry point must be operated in a manner that enables the commissioner
67.26 of human services to:
- 67.27 (1) track critical steps in the reporting, evaluation, referral, response, disposition, and
67.28 investigative process to ensure compliance with all requirements for all reports;
- 67.29 (2) maintain data to facilitate the production of aggregate statistical reports for monitoring
67.30 patterns of abuse, neglect, or exploitation;

68.1 (3) serve as a resource for the evaluation, management, and planning of preventative
68.2 and remedial services for vulnerable adults who have been subject to abuse, neglect, or
68.3 exploitation;

68.4 (4) set standards, priorities, and policies to maximize the efficiency and effectiveness
68.5 of the common entry point; and

68.6 (5) track and manage consumer complaints related to the common entry point.

68.7 (j) The commissioners of human services and health shall collaborate on the creation of
68.8 a system for referring reports to the lead investigative agencies. This system shall enable
68.9 the commissioner of human services to track critical steps in the reporting, evaluation,
68.10 referral, response, disposition, investigation, notification, determination, and appeal processes.

68.11 Sec. 52. Minnesota Statutes 2024, section 626.557, subdivision 9a, is amended to read:

68.12 Subd. 9a. **Evaluation and referral of reports made to common entry point.** (a) The
68.13 common entry point must screen the reports of alleged or suspected maltreatment for
68.14 immediate risk and make all necessary referrals ~~as follows~~ using the referral guidelines
68.15 established by the commissioner and the following:

68.16 (1) if the common entry point determines that there is an immediate need for emergency
68.17 adult protective services, the common entry point agency shall immediately notify the
68.18 appropriate county agency;

68.19 (2) if the report contains suspected criminal activity against a vulnerable adult, the
68.20 common entry point shall immediately notify the appropriate law enforcement agency;

68.21 (3) the common entry point shall refer all reports of alleged or suspected maltreatment
68.22 to the appropriate lead investigative agency as soon as possible, but in any event no longer
68.23 than two working days;

68.24 (4) if the report contains information about a suspicious death, the common entry point
68.25 shall immediately notify the appropriate law enforcement agencies, the local medical
68.26 examiner, and the ombudsman for mental health and developmental disabilities established
68.27 under section 245.92. Law enforcement agencies shall coordinate with the local medical
68.28 examiner and the ombudsman as provided by law; and

68.29 (5) for reports involving multiple locations or changing circumstances, the common
68.30 entry point shall determine the county agency responsible for emergency adult protective
68.31 services and the county responsible as the lead investigative agency, ~~using referral guidelines~~
68.32 ~~established by the commissioner.~~

69.1 (b) If the lead investigative agency receiving a report believes the report was referred
 69.2 by the common entry point in error, the lead investigative agency shall immediately notify
 69.3 the common entry point of the error, including the basis for the lead investigative agency's
 69.4 belief that the referral was made in error. The common entry point shall review the
 69.5 information submitted by the lead investigative agency and immediately refer the report to
 69.6 the appropriate lead investigative agency using the referral guidelines established by the
 69.7 commissioner.

69.8 Sec. 53. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
 69.9 to read:

69.10 Subd. 11b. **County social services agency; responsibilities.** The county social services
 69.11 agency is responsible for supervision of:

69.12 (1) intake decisions for initial disposition of the report;

69.13 (2) agency prioritization used to screen out an adult meeting eligibility for adult protective
 69.14 services as vulnerable and maltreated;

69.15 (3) safety, assessment, and services plans;

69.16 (4) protective service interventions;

69.17 (5) use of guardianship and other involuntary interventions;

69.18 (6) final determination for maltreatment; and

69.19 (7) case closure decisions.

69.20 Sec. 54. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
 69.21 to read:

69.22 Subd. 11c. **County social services agency; referrals.** (a) When the common entry point
 69.23 refers a report to the county social services agency as the lead investigative agency or makes
 69.24 a referral to the county social services agency for emergency adult protective services, or
 69.25 when another lead investigative agency requests adult protective services from the county
 69.26 social services agency for an adult referred to that lead investigative agency by the common
 69.27 entry point, the county social services agency must use the data report system and
 69.28 standardized decision and assessment tools provided by the commissioner of human services.
 69.29 The information entered by the county social services agency into the data system and
 69.30 standardized tools must be accessible to the Department of Human Services for the
 69.31 department to meet federal requirements, evaluate consistent application of policy, review

70.1 quality of services and outcomes for adults, and meet requirements for background studies
70.2 and disqualification of individuals determined responsible for vulnerable adult maltreatment
70.3 under chapter 245C.

70.4 (b) The county social services agency must screen the report using the standardized tools
70.5 provided by the commissioner to determine:

70.6 (1) whether the referred adult meets adult protective services eligibility as potentially
70.7 vulnerable and maltreated under this section; and

70.8 (2) the response time required to initiate adult protective services.

70.9 (c) For reports referred by the common entry point for emergency adult protective
70.10 services, the county social services agency must immediately screen the report to determine
70.11 whether the adult should be accepted for emergency adult protective services. If the adult
70.12 is accepted for emergency adult protective services, the county social services agency must
70.13 immediately offer protective services to prevent further maltreatment and safeguard the
70.14 welfare of the vulnerable adult. Assessment of adults accepted by the county social services
70.15 agency for emergency protective services must be conducted in person by the agency or a
70.16 designee within 24 hours of the agency receiving the referral. When sexual or physical
70.17 abuse is suspected, the county social services agency must immediately arrange for and
70.18 make available to the vulnerable adult appropriate medical examination and services.

70.19 (d) For reports referred by the common entry point to the county as lead investigative
70.20 agency, the county social services agency must screen the report and make an initial
70.21 determination within seven calendar days following receipt of the report from the common
70.22 entry point on whether the adult should be accepted for adult protective services.

70.23 (e) For referrals made for adult protective services by the Department of Human Services
70.24 or the Department of Health in the applicable department's role as the lead investigative
70.25 agency responsible for reports made under this section, the county social services agency
70.26 must screen the report and determine within seven calendar days following receipt of referral
70.27 whether the adult should be accepted for adult protective services.

70.28 (f) If an adult meets eligibility requirements but is not accepted for adult protective
70.29 services based on local agency prioritization, the agency must document the reason for the
70.30 screening decision in the standardized tool provided by the commissioner.

71.1 Sec. 55. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
71.2 to read:

71.3 Subd. 11d. **County social services agency; assessments.** (a) For adults accepted into
71.4 adult protective services, the county social services agency must decide, prior to initiation
71.5 of assessment activities, if the agency must also conduct an investigation for final disposition
71.6 for responsibility of maltreatment in addition to the assessment for adult protective services.

71.7 (b) The county social services agency must conduct assessments concurrently with
71.8 investigations when: (1) the county is both the lead investigative agency and responsible
71.9 for making a final determination of responsibility for maltreatment; or (2) another lead
71.10 investigative agency responsible for the final determination of maltreatment requests
71.11 assistance from the county social services agency.

71.12 (c) The county social services agency must conduct an in-person assessment to initiate
71.13 adult protective services:

71.14 (1) within 24 hours of accepting a referral for emergency protective services;

71.15 (2) within 24 hours of making an initial disposition that the adult is in immediate need
71.16 of protection, unless an in-person response would endanger the safety of the adult; or

71.17 (3) within 72 hours but in no instance later than seven calendar days from the first
71.18 business day after receiving the report for adults accepted for adult protective services.

71.19 (d) The county social services agency must use the standardized decision, assessment,
71.20 and service planning tools provided by the commissioner with all vulnerable adults accepted
71.21 for adult protective services. The county social services agency must involve the vulnerable
71.22 adult in the assessment and service plan. The county social services agency must document
71.23 and update assessment and service plans consistent with significant changes in the vulnerable
71.24 adult's health and safety.

71.25 (e) The county social services agency must notify the vulnerable adult and, if applicable,
71.26 the guardian or health care agent of the vulnerable adult of the results of the assessment and
71.27 service plan, including but not limited to recommendations for protective services intervention
71.28 to stop or prevent maltreatment and to protect the vulnerable adult's health, safety, and
71.29 comfort. When necessary to prevent further maltreatment or safeguard the vulnerable adult,
71.30 the county social services agency may share the results of the assessment with the vulnerable
71.31 adult's primary supports.

72.1 Sec. 56. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
72.2 to read:

72.3 Subd. 11e. **County social services agency; investigations.** (a) The county social services
72.4 agency must investigate for a final disposition of responsibility for maltreatment for an
72.5 allegation of:

72.6 (1) abuse;

72.7 (2) financial abuse by a fiduciary;

72.8 (3) financial exploitation involving a nonfiduciary that may be criminal or that involved
72.9 force, coercion, harassment, deception, fraud, undue influence, or a scam;

72.10 (4) financial exploitation that involved another type of maltreatment;

72.11 (5) caregiver neglect by a paid caregiver or personal care assistance provider under
72.12 chapter 256B;

72.13 (6) caregiver neglect by an unpaid caregiver that resulted in intentional harm to the
72.14 vulnerable adult or involved another type of maltreatment; and

72.15 (7) a situation for which the county social services agency finds that a determination of
72.16 responsibility of maltreatment may safeguard a vulnerable adult or prevent further
72.17 maltreatment.

72.18 (b) The county social services agency must conduct an investigation for final disposition
72.19 of responsibility for maltreatment if the agency receives information during an assessment
72.20 that indicates the presence of any scenario listed in paragraph (a) or subdivision 11f.

72.21 Sec. 57. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
72.22 to read:

72.23 Subd. 11f. **County social services agency; self-neglect.** (a) The county social services
72.24 agency may determine that an allegation that does not result in a determination of
72.25 responsibility for maltreatment is:

72.26 (1) self-neglect;

72.27 (2) neglect by an unpaid caregiver that did not result in intentional harm to the vulnerable
72.28 adult and did not involve another type of alleged maltreatment; or

72.29 (3) financial exploitation by a nonfiduciary that is consistent with the choice of the adult
72.30 and not criminal or involving force, coercion, harassment, deception, fraud, undue influence,
72.31 a scam, or another type of alleged maltreatment.

73.1 (b) An allegation of self-neglect is a substantiated determination if the county social
 73.2 services agency determines that adult protective services are needed.

73.3 Sec. 58. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
 73.4 to read:

73.5 Subd. 11g. **County social services agency; initial contact.** (a) At the initial contact
 73.6 with the vulnerable adult accepted by the county social services agency, the agency must
 73.7 provide the vulnerable adult with information about the process for adult protective services
 73.8 and the vulnerable adult's rights as an adult protective client.

73.9 (b) At initial contact, the county social services agency must inform the individual or
 73.10 entity alleged responsible for maltreatment of the allegation in a manner consistent with
 73.11 requirements under this section to protect the identity of the reporter. The interview with
 73.12 the individual or entity alleged responsible for maltreatment may be postponed at the request
 73.13 of a law enforcement agency or if the interview may endanger the safety of the vulnerable
 73.14 adult.

73.15 Sec. 59. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
 73.16 to read:

73.17 Subd. 11h. **County social services agency; agency authority.** (a) A county social
 73.18 services agency may enter all facilities and business premises of a licensed provider to
 73.19 inspect and copy records as part of an adult protective services assessment or investigation.
 73.20 The licensed provider must provide the county social services agency access to not public
 73.21 data as defined in section 13.02, subdivision 8a, and medical records under sections 144.291
 73.22 to 144.298 that are maintained at the facilities and business premises to the extent that the
 73.23 data and records are necessary to conduct the agency's investigation. The licensed provider
 73.24 must provide the county social services agency access to all available sources of information
 73.25 at the facilities and business premises, not only written records.

73.26 (b) When necessary in order to protect a vulnerable adult from serious harm from
 73.27 maltreatment, the county social services agency may seek any of the following protective
 73.28 services interventions:

73.29 (1) emergency protective services;

73.30 (2) participation of law enforcement or emergency medical services;

73.31 (3) authority from a court to remove an adult from the situation in which maltreatment
 73.32 occurred;

74.1 (4) a restraining order or court order for removal of the perpetrator from the residence
 74.2 of the vulnerable adult pursuant to section 518B.01;

74.3 (5) a referral for a financial transaction hold under chapter 45A or a protective
 74.4 arrangement under this chapter or chapter 524;

74.5 (6) a referral for a representative payee;

74.6 (7) a referral to the prosecuting attorney for possible criminal prosecution of the
 74.7 perpetrator under chapter 609;

74.8 (8) the appointment or replacement of a guardian or conservator pursuant to sections
 74.9 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A when
 74.10 maltreatment has been substantiated and when less restrictive interventions are not sufficient
 74.11 to stop or reduce the risk of serious harm from maltreatment; and

74.12 (9) other interventions recommended by a multidisciplinary team under this section.

74.13 (c) The county social services agency may seek the protective services interventions
 74.14 under paragraph (b) regardless of the vulnerable adult's voluntary or involuntary participation.

74.15 (d) The county social services agency may offer voluntary service interventions to
 74.16 support the vulnerable adult or primary supports to stop, reduce the risk for, or prevent
 74.17 subsequent maltreatment.

74.18 Sec. 60. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
 74.19 to read:

74.20 Subd. 11i. **County social services agency; legal intervention.** (a) In proceedings under
 74.21 sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to
 74.22 petition for guardianship or conservatorship, a county employee must present the petition
 74.23 with representation by the county attorney. The county must contract with or arrange for a
 74.24 suitable person or organization to provide ongoing guardianship services. If the county
 74.25 presents evidence to the court exercising probate jurisdiction that the county has made
 74.26 diligent effort and no other suitable person can be found, a county employee may serve as
 74.27 guardian or conservator.

74.28 (b) The county must not retaliate against the employee for any action taken on behalf
 74.29 of the person subject to guardianship or conservatorship, even if the action is adverse to the
 74.30 county's interests. Any person retaliated against in violation of this subdivision shall have
 74.31 a cause of action against the county and is entitled to reasonable attorney fees and costs of
 74.32 the action if the action is upheld by the court.

75.1 (c) The expenses of a legal intervention must be paid by the county in the case of indigent
75.2 persons under section 524.5-502 and chapter 563.

75.3 Sec. 61. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision
75.4 to read:

75.5 Subd. 11j. **County social services agency; conflict of interest.** (a) A county that
75.6 identifies a potential conflict of interest under paragraph (c) related to an investigation,
75.7 assessment, or protective services intervention must coordinate with another county social
75.8 services agency to delegate the initial county's authority as the lead investigative agency to
75.9 remediate the potential conflict. County social services agencies must cooperate and accept
75.10 jurisdiction when an initial county social services agency identifies a potential conflict of
75.11 interest and requests the other county's assistance.

75.12 (b) The initial county must notify the commissioner of human services when no other
75.13 county is available to accept delegation of adult protective services duties. If the
75.14 commissioner is notified that no other county is available, the commissioner may use the
75.15 authority under subdivision 9a to determine the county social services agency responsible
75.16 as lead investigative agency and for adult protective services.

75.17 (c) A county social services agency employee or designee must not have:

75.18 (1) a personal or family relationship with a party in the investigation or assessment;

75.19 (2) a dual relationship, as defined in Code of Federal Regulations, title 45, section
75.20 1324.401, with the vulnerable adult;

75.21 (3) a personal financial interest or financial relationship with a provider receiving referrals
75.22 from the employee; or

75.23 (4) any other appearance of conflict of interest as determined by the county social services
75.24 agency.

75.25 Sec. 62. Minnesota Statutes 2024, section 626.557, subdivision 12b, is amended to read:

75.26 Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a
75.27 lead investigative agency, the county social ~~service~~ services agency shall maintain appropriate
75.28 records. Data collected by the county social ~~service~~ services agency under this section while
75.29 providing adult protective services are welfare data under section 13.46. Investigative data
75.30 collected under this section are confidential data on individuals or protected nonpublic data
75.31 as defined under section 13.02. Notwithstanding section 13.46, subdivision 1, paragraph
75.32 (a), data under this paragraph that are inactive investigative data on an individual who is a

76.1 vendor of services are private data on individuals, as defined in section 13.02. The identity
76.2 of the reporter may only be disclosed as provided in paragraph (c).

76.3 Data maintained by the common entry point are confidential data on individuals or
76.4 protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the
76.5 common entry point shall maintain data for three calendar years after date of receipt and
76.6 then destroy the data unless otherwise directed by federal requirements.

76.7 (b) The commissioners of health and human services shall prepare an investigation
76.8 memorandum for each report alleging maltreatment investigated under this section. County
76.9 social ~~service~~ services agencies must maintain private data on individuals but are not required
76.10 to prepare an investigation memorandum. During an investigation by the commissioner of
76.11 health or the commissioner of human services, data collected under this section are
76.12 confidential data on individuals or protected nonpublic data as defined in section 13.02.
76.13 Upon completion of the investigation, the data are classified as provided in clauses (1) to
76.14 (3) and paragraph (c).

76.15 (1) The investigation memorandum must contain the following data, which are public:

76.16 (i) the name of the facility investigated;

76.17 (ii) a statement of the nature of the alleged maltreatment;

76.18 (iii) pertinent information obtained from medical or other records reviewed;

76.19 (iv) the identity of the investigator;

76.20 (v) a summary of the investigation's findings;

76.21 (vi) statement of whether the report was found to be substantiated, inconclusive, false,
76.22 or that no determination will be made;

76.23 (vii) a statement of any action taken by the facility;

76.24 (viii) a statement of any action taken by the lead investigative agency; and

76.25 (ix) when a lead investigative agency's determination has substantiated maltreatment, a
76.26 statement of whether an individual, individuals, or a facility were responsible for the
76.27 substantiated maltreatment, if known.

76.28 The investigation memorandum must be written in a manner which protects the identity
76.29 of the reporter and of the vulnerable adult and may not contain the names or, to the extent
76.30 possible, data on individuals or private data listed in clause (2).

77.1 (2) Data on individuals collected and maintained in the investigation memorandum are
77.2 private data, including:

77.3 (i) the name of the vulnerable adult;

77.4 (ii) the identity of the individual alleged to be the perpetrator;

77.5 (iii) the identity of the individual substantiated as the perpetrator; and

77.6 (iv) the identity of all individuals interviewed as part of the investigation.

77.7 (3) Other data on individuals maintained as part of an investigation under this section
77.8 are private data on individuals upon completion of the investigation.

77.9 (c) The name of the reporter must be confidential. The subject of the report may compel
77.10 disclosure of the name of the reporter only with the consent of the reporter or upon a written
77.11 finding by a court that the report was false and there is evidence that the report was made
77.12 in bad faith. This subdivision does not alter disclosure responsibilities or obligations under
77.13 the Rules of Criminal Procedure, except that where the identity of the reporter is relevant
77.14 to a criminal prosecution, the district court shall do an in-camera review prior to determining
77.15 whether to order disclosure of the identity of the reporter.

77.16 (d) Notwithstanding section 138.163, data maintained under this section by the
77.17 commissioners of health and human services and county adult protective services must be
77.18 maintained under the following schedule and then destroyed unless otherwise directed by
77.19 federal requirements:

77.20 (1) data from reports determined to be false, maintained for three years after the finding
77.21 was made for reports under the jurisdiction of the Department of Human Services or the
77.22 Department of Health and five years after the finding was made for reports under the
77.23 jurisdiction of county adult protective services;

77.24 (2) data from reports determined to be inconclusive, maintained for four years after the
77.25 finding was made for reports under the jurisdiction of the Department of Human Services
77.26 or the Department of Health and five years after the finding was made for reports under the
77.27 jurisdiction of county adult protective services;

77.28 (3) data from reports determined to be substantiated, maintained for seven years after
77.29 the finding was made; and

77.30 (4) data from reports which were not investigated by a lead investigative agency and for
77.31 which there is no final disposition, maintained for three years from the date of the report
77.32 for reports under the jurisdiction of the Department of Human Services or the Department

78.1 of Health and five years from the date of the report for reports under the jurisdiction of
 78.2 county adult protective services.

78.3 (e) The commissioners of health and human services shall annually publish on their
 78.4 websites the number and type of reports of alleged maltreatment involving licensed facilities
 78.5 reported under this section, the number of those requiring investigation under this section,
 78.6 and the resolution of those investigations.

78.7 ~~(f) Each lead investigative agency must have a record retention policy.~~

78.8 ~~(g)~~ (f) Lead investigative agencies, county agencies responsible for adult protective
 78.9 services, prosecuting authorities, and law enforcement agencies may exchange not public
 78.10 data, as defined in section 13.02, with a tribal agency, facility, service provider, vulnerable
 78.11 adult, primary support person for a vulnerable adult, emergency management service,
 78.12 financial institution, medical examiner, state licensing board, federal or state agency, the
 78.13 ombudsman for long-term care, or the ombudsman for mental health and developmental
 78.14 disabilities, if the agency or authority providing the data determines that the data are pertinent
 78.15 and necessary to prevent further maltreatment of a vulnerable adult, to safeguard a vulnerable
 78.16 adult, or for an investigation under this section. Data collected under this section must be
 78.17 made available to prosecuting authorities and law enforcement officials, local county
 78.18 agencies, the commissioner of human services as the state Medicaid agency, and licensing
 78.19 agencies investigating the alleged maltreatment under this section. The lead investigative
 78.20 agency shall exchange not public data with the vulnerable adult maltreatment review panel
 78.21 established in section 256.021 if the data are pertinent and necessary for a review requested
 78.22 under that section. Notwithstanding section 138.17, upon completion of the review, not
 78.23 public data received by the review panel must be destroyed.

78.24 ~~(h)~~ (g) Each lead investigative agency shall keep records of the length of time it takes
 78.25 to complete its investigations.

78.26 ~~(i)~~ (h) A lead investigative agency may notify other affected parties and their authorized
 78.27 representative if the lead investigative agency has reason to believe maltreatment has occurred
 78.28 and determines the information will safeguard the well-being of the affected parties or dispel
 78.29 widespread rumor or unrest in the affected facility.

78.30 ~~(j)~~ (i) Under any notification provision of this section, where federal law specifically
 78.31 prohibits the disclosure of patient identifying information, a lead investigative agency may
 78.32 not provide any notice unless the vulnerable adult has consented to disclosure in a manner
 78.33 which conforms to federal requirements.

79.1 (j) When a county agency acting as the lead investigative agency is aware the person
 79.2 determined responsible for maltreatment is a guardian or conservator appointed under
 79.3 chapter 524, the county agency must share the final determination with the Minnesota
 79.4 Judicial Branch within 14 calendar days of the determination.

79.5 Sec. 63. Minnesota Statutes 2024, section 626.5572, subdivision 2, is amended to read:

79.6 Subd. 2. **Abuse.** "Abuse" means:

79.7 (a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate,
 79.8 or aiding and abetting a violation of:

79.9 (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

79.10 (2) the use of drugs to injure or facilitate crime as defined in section 609.235;

79.11 (3) the solicitation, inducement, and promotion of prostitution as defined in section
 79.12 609.322; and

79.13 (4) criminal sexual conduct in the first through fifth degrees as defined in sections
 79.14 609.342 to 609.3451.

79.15 A violation includes any action that meets the elements of the crime, regardless of
 79.16 whether there is a criminal proceeding or conviction.

79.17 (b) Conduct which is not an accident or therapeutic conduct as defined in this section,
 79.18 which produces or could reasonably be expected to produce physical pain or injury or
 79.19 emotional distress including, but not limited to, the following:

79.20 (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable
 79.21 adult;

79.22 (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable
 79.23 adult or the treatment of a vulnerable adult which would be considered by a reasonable
 79.24 person to be disparaging, derogatory, humiliating, harassing, or threatening; or

79.25 (3) use of any aversive or deprivation procedure, unreasonable confinement, or
 79.26 involuntary seclusion, including the forced separation of the vulnerable adult from other
 79.27 persons against the will of the vulnerable adult or the legal representative of the vulnerable
 79.28 adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter
 79.29 9544.

80.1 (c) Any contact with the vulnerable adult that is not therapeutic conduct and a reasonable
 80.2 person would consider a sexual act or any nonconsensual sexual interaction with the
 80.3 vulnerable adult, including but not limited to:

80.4 (1) making, viewing, or sharing sexual images or videos with or of the vulnerable adult;
 80.5 and

80.6 (2) using oral, written, gestured, or electronic communication that is sexually harassing,
 80.7 including but not limited to unwelcome sexual advances or requests for sexual favors.

80.8 ~~(e)~~ (d) Any sexual contact or penetration as defined in section 609.341, between a facility
 80.9 staff person or a person providing services in the facility and a resident, patient, or client
 80.10 of that facility.

80.11 ~~(d)~~ (e) The act of forcing, compelling, coercing, or enticing a vulnerable adult against
 80.12 the vulnerable adult's will to perform services for the advantage of another.

80.13 ~~(e)~~ (f) For purposes of this section, a vulnerable adult is not abused for the sole reason
 80.14 that the vulnerable adult or a person with authority to make health care decisions for the
 80.15 vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section
 80.16 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority
 80.17 and within the boundary of reasonable medical practice, to any therapeutic conduct, including
 80.18 any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition
 80.19 of the vulnerable adult or, where permitted under law, to provide nutrition and hydration
 80.20 parenterally or through intubation. This paragraph does not enlarge or diminish rights
 80.21 otherwise held under law by:

80.22 (1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an
 80.23 involved family member, to consent to or refuse consent for therapeutic conduct; or

80.24 (2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

80.25 ~~(f)~~ (g) For purposes of this section, a vulnerable adult is not abused for the sole reason
 80.26 that the vulnerable adult, a person with authority to make health care decisions for the
 80.27 vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or
 80.28 prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of
 80.29 medical care, provided that this is consistent with the prior practice or belief of the vulnerable
 80.30 adult or with the expressed intentions of the vulnerable adult.

80.31 ~~(g)~~ (h) For purposes of this section, a vulnerable adult is not abused for the sole reason
 80.32 that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional
 80.33 dysfunction or undue influence, engages in consensual sexual contact with:

81.1 (1) a person, including a facility staff person, when a consensual sexual personal
81.2 relationship existed prior to the caregiving relationship; or

81.3 (2) a personal care attendant, regardless of whether the consensual sexual personal
81.4 relationship existed prior to the caregiving relationship.

81.5 Sec. 64. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision
81.6 to read:

81.7 Subd. 3a. **Adult protective services.** "Adult protective services" means an adult
81.8 protection program administered by a county social services agency under the authority of
81.9 the agency's governing body or delegated to a Tribal government by the commissioner of
81.10 human services to support adults referred for maltreatment to live safely and with dignity.

81.11 Sec. 65. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision
81.12 to read:

81.13 Subd. 3b. **Assessment.** "Assessment" means a structured process conducted by a county
81.14 social services agency to review the safety, strengths, and needs of an adult referred as
81.15 vulnerable and maltreated and accepted by the agency for adult protective services and to
81.16 develop a service plan to stop, prevent, and reduce risk of maltreatment for the adult using
81.17 standardized tools provided by the Department of Human Services.

81.18 Sec. 66. Minnesota Statutes 2024, section 626.5572, subdivision 9, is amended to read:

81.19 Subd. 9. **Financial exploitation.** "Financial exploitation" means:

81.20 (a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent
81.21 regulations, contractual obligations, documented consent by a competent person, or the
81.22 obligations of a responsible party under section 144.6501, a person:

81.23 (1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable
81.24 adult which results or is likely to result in detriment to the vulnerable adult; or

81.25 (2) fails to use the financial resources of the vulnerable adult to provide food, clothing,
81.26 shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the
81.27 failure results or is likely to result in detriment to the vulnerable adult.

81.28 (b) In the absence of legal authority a person:

81.29 (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

82.1 (2) obtains for the actor or another the performance of services by ~~a third person~~ the
 82.2 vulnerable adult for the wrongful profit or advantage of the actor or another to the detriment
 82.3 of the vulnerable adult;

82.4 (3) acquires possession or control of, or an interest in, funds or property of a vulnerable
 82.5 adult through the use of undue influence, harassment, duress, deception, or fraud; or

82.6 (4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's
 82.7 will to perform services for the profit or advantage of another.

82.8 (c) Nothing in this definition requires a facility or caregiver to provide financial
 82.9 management or supervise financial management for a vulnerable adult except as otherwise
 82.10 required by law.

82.11 Sec. 67. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision
 82.12 to read:

82.13 Subd. 12a. **Investigation.** "Investigation" means activities for fact gathering conducted
 82.14 by the lead investigative agency to make a final determination of maltreatment.

82.15 Sec. 68. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended
 82.16 to read:

82.17 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
 82.18 administrative agency responsible for investigating reports made under section 626.557.

82.19 (a) The Department of Health is the lead investigative agency for facilities or services
 82.20 licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding
 82.21 care homes, hospice providers, residential facilities that are also federally certified as
 82.22 intermediate care facilities that serve people with developmental disabilities, or any other
 82.23 facility or service not listed in this subdivision that is licensed or required to be licensed by
 82.24 the Department of Health for the care of vulnerable adults. "Home care provider" has the
 82.25 meaning provided in section 144A.43, subdivision 4, and applies when care or services are
 82.26 delivered in the vulnerable adult's home.

82.27 (b) The Department of Human Services is the lead investigative agency for facilities or
 82.28 services licensed or required to be licensed as adult day care, adult foster care, community
 82.29 residential settings, programs for people with disabilities, EIDBI agencies, family adult day
 82.30 services, mental health programs, mental health clinics, substance use disorder programs,
 82.31 the Minnesota Sex Offender Program, or any other facility or service not listed in this
 82.32 subdivision that is licensed or required to be licensed by the Department of Human Services.

83.1 The Department of Human Services is also the lead investigative agency for unlicensed
83.2 EIDBI agencies under section 256B.0949.

83.3 (c) The county social ~~service~~ services agency adult protective services or ~~its~~ the agency's
83.4 designee or a federally recognized Indian Tribe that entered into a contractual agreement
83.5 with the commissioner of human services to operate adult protective services is the lead
83.6 investigative agency for all other reports, including but not limited to reports involving
83.7 vulnerable adults receiving services from a personal care provider organization under section
83.8 256B.0659 or 256B.85.

83.9 Sec. 69. Minnesota Statutes 2024, section 626.5572, subdivision 17, is amended to read:

83.10 Subd. 17. **Neglect.** (a) "Neglect" means neglect by a caregiver or self-neglect.

83.11 (b) "Caregiver neglect" means the failure or omission by a caregiver to supply a
83.12 vulnerable adult with care or services, including but not limited to, food, clothing, shelter,
83.13 health care, or supervision which is:

83.14 (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or
83.15 mental health or safety, considering the physical and mental capacity or dysfunction of the
83.16 vulnerable adult; and

83.17 (2) which is not the result of an accident or therapeutic conduct.

83.18 (c) "Self-neglect" means neglect by a vulnerable adult of the vulnerable adult's own
83.19 food, clothing, shelter, health care, financial management, or other services that are not the
83.20 responsibility of a caregiver which a reasonable person would deem essential to obtain or
83.21 maintain the vulnerable adult's health, safety, or comfort.

83.22 (d) For purposes of this section, a vulnerable adult is not neglected for the sole reason
83.23 that:

83.24 (1) the vulnerable adult or a person with authority to make health care decisions for the
83.25 vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections
83.26 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with
83.27 that authority and within the boundary of reasonable medical practice, to any therapeutic
83.28 conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical
83.29 or mental condition of the vulnerable adult, or, where permitted under law, to provide
83.30 nutrition and hydration parenterally or through intubation; this paragraph does not enlarge
83.31 or diminish rights otherwise held under law by:

- 84.1 (i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an
84.2 involved family member, to consent to or refuse consent for therapeutic conduct; or
- 84.3 (ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; ~~or~~
- 84.4 (2) the vulnerable adult, a person with authority to make health care decisions for the
84.5 vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or
84.6 prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of
84.7 medical care, provided that this is consistent with the prior practice or belief of the vulnerable
84.8 adult or with the expressed intentions of the vulnerable adult;
- 84.9 (3) the vulnerable adult, who is not impaired in judgment or capacity by mental or
84.10 emotional dysfunction or undue influence, engages in consensual sexual contact with:
- 84.11 (i) a person including a facility staff person when a consensual sexual personal
84.12 relationship existed prior to the caregiving relationship; or
- 84.13 (ii) a personal care attendant, regardless of whether the consensual sexual personal
84.14 relationship existed prior to the caregiving relationship; ~~or~~
- 84.15 (4) an individual makes an error in the provision of therapeutic conduct to a vulnerable
84.16 adult which does not result in injury or harm which reasonably requires medical or mental
84.17 health care; or
- 84.18 (5) an individual makes an error in the provision of therapeutic conduct to a vulnerable
84.19 adult that results in injury or harm, which reasonably requires the care of a physician, and:
- 84.20 (i) the necessary care is provided in a timely fashion as dictated by the condition of the
84.21 vulnerable adult;
- 84.22 (ii) if after receiving care, the health status of the vulnerable adult can be reasonably
84.23 expected, as determined by the attending physician, to be restored to the vulnerable adult's
84.24 preexisting condition;
- 84.25 (iii) the error is not part of a pattern of errors by the individual;
- 84.26 (iv) if in a facility, the error is immediately reported as required under section 626.557,
84.27 and recorded internally in the facility;
- 84.28 (v) if in a facility, the facility identifies and takes corrective action and implements
84.29 measures designed to reduce the risk of further occurrence of this error and similar errors;
84.30 and

85.1 (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently
85.2 documented for review and evaluation by the facility and any applicable licensing,
85.3 certification, and ombudsman agency.

85.4 (e) Nothing in this definition requires a caregiver, if regulated, to provide services in
85.5 excess of those required by the caregiver's license, certification, registration, or other
85.6 regulation.

85.7 (f) If the findings of an investigation by a lead investigative agency result in a
85.8 determination of substantiated maltreatment for the sole reason that the actions required of
85.9 a facility under paragraph (d), clause (5), item (iv), (v), or (vi), were not taken, then the
85.10 facility is subject to a correction order. An individual will not be found to have neglected
85.11 or maltreated the vulnerable adult based solely on the facility's not having taken the actions
85.12 required under paragraph (d), clause (5), item (iv), (v), or (vi). This must not alter the lead
85.13 investigative agency's determination of mitigating factors under section 626.557, subdivision
85.14 9c, paragraph (f).

85.15 Sec. 70. Laws 2024, chapter 125, article 1, section 47, is amended to read:

85.16 Sec. 47. **DIRECTION TO COMMISSIONER; PEDIATRIC HOSPITAL-TO-HOME**
85.17 **TRANSITION PILOT PROGRAM.**

85.18 (a) The commissioner of human services must award a single competitive grant to a
85.19 home care nursing provider to develop and implement, in coordination with the commissioner
85.20 of health, Fairview Masonic Children's Hospital, Gillette Children's Specialty Healthcare,
85.21 and Children's Minnesota of St. Paul and Minneapolis, a pilot program to expedite and
85.22 facilitate pediatric hospital-to-home discharges for patients receiving services in this state
85.23 under medical assistance, including under the community alternative care waiver, community
85.24 access for disability inclusion waiver, and developmental disabilities waiver.

85.25 (b) Grant money awarded under this section must be used only to support the
85.26 administrative, training, and auxiliary services necessary to reduce:

85.27 (1) delayed discharge days due to unavailability of home care nursing staffing to
85.28 accommodate complex pediatric patients;

85.29 (2) avoidable rehospitalization days for pediatric patients;

85.30 (3) unnecessary emergency department utilization by pediatric patients following
85.31 discharge;

85.32 (4) long-term nursing needs for pediatric patients; and

86.1 (5) the number of school days missed by pediatric patients.

86.2 (c) Grant money must not be used to supplant payment rates for services covered under
86.3 Minnesota Statutes, chapter 256B.

86.4 (d) No later than December 15, ~~2026~~ 2027, the commissioner must prepare a report
86.5 summarizing the impact of the pilot program that includes but is not limited to: (1) the
86.6 number of delayed discharge days eliminated; (2) the number of rehospitalization days
86.7 eliminated; (3) the number of unnecessary emergency department admissions eliminated;
86.8 (4) the number of missed school days eliminated; and (5) an estimate of the return on
86.9 investment of the pilot program.

86.10 (e) The commissioner must submit the report under paragraph (d) to the chairs and
86.11 ranking minority members of the legislative committees with jurisdiction over health and
86.12 human services finance and policy.

86.13 Sec. 71. **HOUSING STABILIZATION SERVICES REDESIGN.**

86.14 **Subdivision 1. Direction to the commissioner.** The commissioner of human services
86.15 must develop recommendations for establishing a program to support individuals
86.16 experiencing or at risk of homelessness to obtain and maintain safe and stable housing.

86.17 **Subd. 2. Recommendations.** In developing recommendations, the commissioner must:

86.18 (1) prioritize establishing a housing services benefit specifically for Minnesota Tribal
86.19 governments and urban Indian organizations;

86.20 (2) utilize evidence-based and promising practices to prevent and reduce homelessness;

86.21 (3) identify gaps in available housing services and supports and not duplicate any existing
86.22 programs;

86.23 (4) identify expected outcomes and measures to track effectiveness of the proposed
86.24 program;

86.25 (5) incorporate tools and system changes to protect program integrity and prevent fraud,
86.26 waste, and abuse; and

86.27 (6) include statutory changes and state appropriations to implement the proposed program.

86.28 **Subd. 3. Community engagement.** In developing recommendations, the commissioner
86.29 must consult with the legislature, other state agencies, Tribal Nations, and community
86.30 partners, including counties, providers, health plans, and people experiencing or at risk of
86.31 homelessness.

87.1 Subd. 4. **Legislative report.** By September 15, 2027, the commissioner must submit to
 87.2 the chairs and ranking minority members of the legislative committees with jurisdiction
 87.3 over health and human services policy and finance a report including final recommendations
 87.4 to establish both a housing services benefit specifically for Tribal governments and urban
 87.5 Indian organizations and a statewide housing services benefit.

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

87.7 Sec. 72. **OPTUM PROHIBITED FROM DISSEMINATING PRIVATE DATA.**

87.8 Optum, Inc., must not sell, share, or disseminate any private data on individuals, as
 87.9 defined in Minnesota Statutes, section 13.02, subdivision 12, that Optum receives under or
 87.10 incidental to Optum's contract or engagement with the Department of Human Services
 87.11 pursuant to the governor's Executive Order No. 25-10.

87.12 Sec. 73. **REVISOR INSTRUCTION.**

87.13 (a) The revisor of statutes shall renumber the definitions in Minnesota Statutes, section
 87.14 256B.85, subdivision 2, and the definitions in Minnesota Statutes, section 256B.851,
 87.15 subdivision 2, as subdivisions in Minnesota Statutes, section 256B.8502, rearranging the
 87.16 renumbered and existing definitions in Minnesota Statutes, section 256B.8502, as necessary
 87.17 to place them in alphabetical order. The revisor of statutes shall revise all statutory
 87.18 cross-references consistent with this recoding.

87.19 (b) If a provision of Minnesota Statutes, section 256B.85, subdivision 2, or 256B.851,
 87.20 subdivision 2, is amended or repealed in the 2026 regular legislative session, the revisor of
 87.21 statutes shall codify the amendment or repealer in Minnesota Statutes, section 256B.8502,
 87.22 notwithstanding any other law to the contrary.

87.23 (c) In each section of Minnesota Statutes referred to in column A, the revisor of statutes
 87.24 shall delete the reference in column B and insert the reference in column C.

<u>A</u>	<u>B</u>	<u>C</u>
87.25		
87.26 <u>Minnesota Statutes, section</u>	<u>subdivision 7</u>	<u>section 245A.03, subdivision</u>
87.27 <u>245A.03, subdivision 9</u>		<u>7b</u>
87.28 <u>Minnesota Statutes, section</u>	<u>section 245A.03, subdivision</u>	<u>section 245A.03, subdivisions</u>
87.29 <u>245A.11, subdivision 2a,</u>	<u>7</u>	<u>7b to 7d</u>
87.30 <u>paragraph (e)</u>		
87.31 <u>Minnesota Statutes, section</u>	<u>section 245A.03, subdivision</u>	
87.32 <u>245A.11, subdivision 2a,</u>	<u>7, paragraph (a), clause (5)</u>	
87.33 <u>paragraph (h)</u>		

88.1	<u>Minnesota Statutes, section 256B.092, subdivision 11, paragraph (c)</u>	<u>section 245A.03, subdivision 7, paragraph (f)</u>	
88.4	<u>Minnesota Statutes, section 256B.092, subdivision 11a, paragraph (b)</u>	<u>section 245A.03, subdivision 7</u>	<u>section 245A.03, subdivisions 7b to 7d</u>
88.7	<u>Minnesota Statutes, section 256B.092, subdivision 11a, paragraph (c)</u>	<u>section 245A.03, subdivision 7, paragraph (a)</u>	<u>section 245A.03, subdivision 7b</u>
88.10	<u>Minnesota Statutes, section 256B.092, subdivision 13, paragraph (c)</u>	<u>section 245A.03, subdivision 7, paragraph (a)</u>	<u>section 245A.03, subdivision 7b</u>
88.13	<u>Minnesota Statutes, section 256B.49, subdivision 24, paragraph (c)</u>	<u>section 245A.03, subdivision 7, paragraph (a)</u>	<u>section 245A.03, subdivision 7b</u>
88.16	<u>Minnesota Statutes, section 256B.49, subdivision 29, paragraph (b)</u>	<u>section 245A.03, subdivision 7</u>	<u>section 245A.03, subdivisions 7b to 7d</u>
88.19	<u>Minnesota Statutes, section 256B.49, subdivision 29, paragraph (c)</u>	<u>section 245A.03, subdivision 7, paragraph (a)</u>	<u>section 245A.03, subdivision 7b</u>
88.22	<u>Minnesota Statutes, section 256B.493, subdivision 1</u>	<u>section 245A.03, subdivision 7, paragraphs (c) and (d)</u>	

88.24 **Sec. 74. REPEALER.**

88.25 (a) Minnesota Statutes 2024, sections 256B.051, subdivisions 1, 4, and 7; 256B.5012,
88.26 subdivisions 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, and 16; and 626.557, subdivision 10, are
88.27 repealed.

88.28 (b) Minnesota Statutes 2025 Supplement, sections 245A.04, subdivision 7; and 256B.051,
88.29 subdivisions 2, 3, 5, 6, 6a, 6b, 8, 9, and 10, are repealed.

88.30 (c) Laws 2025, First Special Session chapter 3, article 18, section 3, is repealed.

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

88.32 **ARTICLE 3**

88.33 **SUBSTANCE USE DISORDER TREATMENT POLICY**

88.34 Section 1. Minnesota Statutes 2024, section 245F.02, subdivision 17, is amended to read:

88.35 Subd. 17. **Peer recovery support services.** "Peer recovery support services" means
88.36 services provided according to section ~~245F.08, subdivision 3~~ 254B.052.

89.1 Sec. 2. Minnesota Statutes 2025 Supplement, section 245F.08, subdivision 3, is amended
89.2 to read:

89.3 Subd. 3. **Peer recovery support services.** Peer recovery support services must meet the
89.4 requirements in section ~~245G.07, subdivision 2a, paragraph (b), clause (2)~~ 254B.052, and
89.5 must be provided by a person who is qualified according to the requirements in section
89.6 ~~245F.15, subdivision 7~~ 245I.04, subdivisions 18 and 19.

89.7 Sec. 3. Minnesota Statutes 2024, section 245F.15, subdivision 7, is amended to read:

89.8 Subd. 7. **Recovery peer qualifications.** Recovery peers must:

89.9 (1) meet the qualifications in section 245I.04, subdivision 18; and

89.10 (2) provide services according to the scope of practice established in section 245I.04,
89.11 subdivision 19, ~~under the supervision of an alcohol and drug counselor.~~

89.12 Sec. 4. Minnesota Statutes 2024, section 245G.06, subdivision 4, is amended to read:

89.13 Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a
89.14 service discharge summary for each client. The service discharge summary must be
89.15 completed within five days of the client's service termination, excluding weekends and
89.16 holidays. A copy of the client's service discharge summary must be provided to the client
89.17 upon the client's request.

89.18 (b) The service discharge summary must be recorded in the six dimensions listed in
89.19 section 254B.04, subdivision 4, and include the following information:

89.20 (1) the client's issues, strengths, and needs while participating in treatment, including
89.21 services provided;

89.22 (2) the client's progress toward achieving each goal identified in the individual treatment
89.23 plan;

89.24 (3) a risk rating and description for each of the ASAM six dimensions;

89.25 (4) the reasons for and circumstances of service termination. If a program discharges a
89.26 client at staff request, the reason for discharge and the procedure followed for the decision
89.27 to discharge must be documented and comply with the requirements in section 245G.14,
89.28 subdivision 3, clause (3);

89.29 (5) the client's living arrangements at service termination;

90.1 (6) continuing care recommendations, including transitions between more or less intense
90.2 services, or more frequent to less frequent services, and referrals made with specific attention
90.3 to continuity of care for mental health, as needed; and

90.4 (7) service termination diagnosis.

90.5 Sec. 5. Minnesota Statutes 2025 Supplement, section 245G.11, subdivision 7, is amended
90.6 to read:

90.7 Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination
90.8 must be provided by qualified staff. An individual is qualified to provide treatment
90.9 coordination if the individual meets the qualifications of an alcohol and drug counselor
90.10 under subdivision 5 or if the individual:

90.11 (1) is skilled in the process of identifying and assessing a wide range of client needs;

90.12 (2) is knowledgeable about local community resources and how to use those resources
90.13 for the benefit of the client;

90.14 (3) has completed 15 hours of education or training on substance use disorder,
90.15 co-occurring conditions, and care coordination for individuals with substance use disorder
90.16 or co-occurring conditions that is consistent with national evidence-based standards;

90.17 (4) meets one of the following criteria:

90.18 ~~(i) has a bachelor's degree in one of the behavioral sciences or related fields;~~

90.19 ~~(ii)~~ (i) has a high school diploma or equivalent; or

90.20 ~~(iii)~~ (ii) is a mental health practitioner who meets the qualifications under section 245I.04,
90.21 subdivision 4; and

90.22 (5) either has at least 1,000 hours of supervised experience working with individuals
90.23 with substance use disorder or co-occurring conditions or receives treatment supervision at
90.24 least once per week until obtaining 1,000 hours of supervised experience working with
90.25 individuals with substance use disorder or co-occurring conditions.

90.26 (b) A treatment coordinator must receive the following levels of supervision from an
90.27 alcohol and drug counselor or a mental health professional whose scope of practice includes
90.28 substance use disorder treatment and assessments:

90.29 (1) for a treatment coordinator that has not obtained 1,000 hours of supervised experience
90.30 under paragraph (a), clause (5), at least one hour of supervision per week; or

91.1 (2) for a treatment coordinator that has obtained at least 1,000 hours of supervised
 91.2 experience under paragraph (a), clause (5), at least one hour of supervision per month.

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

91.4 Sec. 6. Minnesota Statutes 2024, section 245G.11, subdivision 8, is amended to read:

91.5 Subd. 8. **Recovery peer qualifications.** A recovery peer must:

91.6 (1) meet the qualifications in section 245I.04, subdivision 18; and

91.7 (2) provide services according to the scope of practice established in section 245I.04,
 91.8 subdivision 19, ~~under the supervision of an alcohol and drug counselor.~~

91.9 Sec. 7. Minnesota Statutes 2025 Supplement, section 254A.03, subdivision 3, is amended
 91.10 to read:

91.11 Subd. 3. **Rules for substance use disorder care.** (a) An eligible vendor of comprehensive
 91.12 assessments under section 254B.0501 may determine the appropriate level of substance use
 91.13 disorder treatment for a recipient of public assistance. The process for determining an
 91.14 individual's financial eligibility for the behavioral health fund or determining an individual's
 91.15 enrollment in or eligibility for a publicly subsidized health plan is not affected by the
 91.16 individual's choice to access a comprehensive assessment for placement.

91.17 ~~(b) The commissioner shall develop and implement a utilization review process for~~
 91.18 ~~publicly funded treatment placements to monitor and review the clinical appropriateness~~
 91.19 ~~and timeliness of all publicly funded placements in treatment.~~

91.20 ~~(e)~~ (b) If a screen result is positive for alcohol or substance misuse, a brief screening for
 91.21 alcohol or substance use disorder that is provided to a recipient of public assistance within
 91.22 a primary care clinic, hospital, or other medical setting or school setting establishes medical
 91.23 necessity and approval for an initial set of substance use disorder services identified in
 91.24 section 254B.0505. The initial set of services approved for a recipient whose screen result
 91.25 is positive may include any combination of up to four hours of individual or group substance
 91.26 use disorder treatment, two hours of substance use disorder treatment coordination, or two
 91.27 hours of substance use disorder peer support services provided by a qualified individual
 91.28 according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph
 91.29 (a) to be approved for additional treatment services. A comprehensive assessment pursuant
 91.30 to section 245G.05 is not required to receive the initial set of services allowed under this
 91.31 subdivision. A positive screen result establishes eligibility for the initial set of services
 91.32 allowed under this subdivision.

92.1 ~~(d)~~ (c) An individual may choose to obtain a comprehensive assessment as provided in
92.2 section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled
92.3 provider that is licensed to provide the level of service authorized pursuant to section
92.4 254A.19, subdivision 3. If the individual is enrolled in a prepaid health plan, the individual
92.5 must comply with any provider network requirements or limitations.

92.6 Sec. 8. Minnesota Statutes 2025 Supplement, section 254B.0501, subdivision 6, is amended
92.7 to read:

92.8 Subd. 6. **Recovery community organizations.** (a) A recovery community organization
92.9 that meets the requirements of clauses (1) to (15), complies with the training requirements
92.10 in section 254B.052, subdivision 4, and meets certification requirements of the Minnesota
92.11 Alliance of Recovery Community Organizations or another Minnesota statewide recovery
92.12 organization identified by the commissioner is an eligible vendor of peer recovery support
92.13 services. If the commissioner does not identify another statewide recovery organization, or
92.14 the Minnesota Alliance of Recovery Community Organizations or the statewide recovery
92.15 organization identified by the commissioner is not reasonably positioned to certify vendors,
92.16 the commissioner must determine the eligibility of a vendor of peer recovery support services.
92.17 A Minnesota statewide recovery organization identified by the commissioner must update
92.18 recovery community organization applicants for certification on the status of the application
92.19 within 45 days of receipt. If the approved statewide recovery organization denies an
92.20 application, it must provide a written explanation for the denial to the recovery community
92.21 organization. Eligible vendors under this paragraph must:

92.22 (1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be
92.23 free from conflicting self-interests, and be autonomous in decision-making, program
92.24 development, peer recovery support services provided, and advocacy efforts for the purpose
92.25 of supporting the recovery community organization's mission;

92.26 (2) be led and governed by individuals in the recovery community, with more than 50
92.27 percent of the board of directors or advisory board members self-identifying as people in
92.28 personal recovery from substance use disorders;

92.29 (3) have a mission statement and conduct corresponding activities indicating that the
92.30 organization's primary purpose is to support recovery from substance use disorder;

92.31 (4) demonstrate ongoing community engagement with the identified primary region and
92.32 population served by the organization, including individuals in recovery and their families,
92.33 friends, and recovery allies;

93.1 (5) be accountable to the recovery community through documented priority-setting and
93.2 participatory decision-making processes that promote the engagement of, and consultation
93.3 with, people in recovery and their families, friends, and recovery allies;

93.4 (6) provide nonclinical peer recovery support services, including but not limited to
93.5 recovery support groups, recovery coaching, telephone recovery support, skill-building,
93.6 and harm-reduction activities, and provide recovery public education and advocacy;

93.7 (7) have written policies that allow for and support opportunities for all paths toward
93.8 recovery and refrain from excluding anyone based on their chosen recovery path, which
93.9 may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based
93.10 paths;

93.11 (8) maintain organizational practices to meet the needs of Black, Indigenous, and people
93.12 of color communities, LGBTQ+ communities, and other underrepresented or marginalized
93.13 communities. Organizational practices may include board and staff training, service offerings,
93.14 advocacy efforts, and culturally informed outreach and services;

93.15 (9) use recovery-friendly language in all media and written materials that is supportive
93.16 of and promotes recovery across diverse geographical and cultural contexts and reduces
93.17 stigma;

93.18 (10) establish and maintain a publicly available recovery community organization code
93.19 of ethics and grievance policy and procedures;

93.20 (11) not classify or treat any recovery peer hired on or after July 1, 2024, as an
93.21 independent contractor;

93.22 (12) not classify or treat any recovery peer as an independent contractor on or after
93.23 January 1, 2025;

93.24 (13) provide an orientation for recovery peers that includes an overview of the consumer
93.25 advocacy services provided by the Ombudsman for Mental Health and Developmental
93.26 Disabilities and other relevant advocacy services;

93.27 (14) provide notice to peer recovery support services participants that includes the
93.28 following statement: "If you have a complaint about the provider or the person providing
93.29 your peer recovery support services, you may contact the Minnesota Alliance of Recovery
93.30 Community Organizations. You may also contact the Office of Ombudsman for Mental
93.31 Health and Developmental Disabilities." The statement must also include:

94.1 (i) the telephone number, website address, email address, and mailing address of the
 94.2 Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman
 94.3 for Mental Health and Developmental Disabilities;

94.4 (ii) the recovery community organization's name, address, email, telephone number, and
 94.5 name or title of the person at the recovery community organization to whom problems or
 94.6 complaints may be directed; and

94.7 (iii) a statement that the recovery community organization will not retaliate against a
 94.8 peer recovery support services participant because of a complaint; and

94.9 (15) comply with the requirements of section 245A.04, subdivision 15a.

94.10 (b) A recovery community organization approved by the commissioner before June 30,
 94.11 2023, must have begun the application process as required by an approved certifying or
 94.12 accrediting entity and have begun the process to meet the requirements under paragraph (a)
 94.13 by September 1, 2024, in order to be considered as an eligible vendor of peer recovery
 94.14 support services.

94.15 (c) A recovery community organization that is aggrieved by a certification determination
 94.16 and believes it meets the requirements under paragraph (a) may appeal the determination
 94.17 under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an
 94.18 eligible vendor. If the human services judge determines that the recovery community
 94.19 organization meets the requirements under paragraph (a), the recovery community
 94.20 organization is an eligible vendor of peer recovery support services for up to two years from
 94.21 the date of the determination. After two years, the recovery community organization must
 94.22 apply for certification under paragraph (a) to continue to be an eligible vendor of peer
 94.23 recovery support services.

94.24 (d) All recovery community organizations must be certified by an entity listed in
 94.25 paragraph (a) by June 30, ~~2027~~ 2026.

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

94.27 Sec. 9. Minnesota Statutes 2025 Supplement, section 254B.0505, subdivision 8, is amended
 94.28 to read:

94.29 Subd. 8. ~~Peer recovery support services~~ **Utilization review requirements.** Eligible
 94.30 vendors of ~~peer recovery support services~~ in subdivision 1, clauses (1) to (10), must:

94.31 ~~(1)~~ submit to a review by the commissioner of up to ten percent of all medical assistance
 94.32 and behavioral health fund claims to determine the medical necessity ~~of peer recovery~~

95.1 ~~support services for entities billing for peer recovery support services individually and not~~
 95.2 ~~receiving a daily rate; and~~

95.3 ~~(2) limit an individual client to 14 hours per week for peer recovery support services~~
 95.4 ~~from an individual provider of peer recovery support services.~~

95.5 Sec. 10. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding
 95.6 a subdivision to read:

95.7 Subd. 9. **Monetary recovery.** Reimbursement for services authorized under this chapter
 95.8 that are not provided in accordance with this chapter are subject to monetary recovery under
 95.9 section 256B.064 as money improperly paid.

95.10 Sec. 11. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding
 95.11 a subdivision to read:

95.12 Subd. 10. **Withdrawal management services.** For withdrawal management services
 95.13 provided by an eligible vendor that is licensed under chapter 245F as a clinically managed
 95.14 withdrawal management program or as a medically monitored withdrawal management
 95.15 program, utilization review, as defined in section 62M.02, is prohibited until five calendar
 95.16 days after the date of service initiation.

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

95.19 Sec. 12. Minnesota Statutes 2024, section 254B.052, subdivision 1, is amended to read:

95.20 Subdivision 1. **Peer recovery support services; service requirements.** (a) Peer recovery
 95.21 support services are face-to-face interactions between a recovery peer and a client, on a
 95.22 one-on-one basis, in which specific goals identified in an individual recovery plan, treatment
 95.23 plan, or stabilization plan are discussed and addressed. Peer recovery support services are
 95.24 provided to promote a client's recovery goals, self-sufficiency, self-advocacy, and
 95.25 development of natural supports and to support maintenance of a client's recovery.

95.26 (b) Peer recovery support services must be provided according to (1) an individual
 95.27 recovery plan if provided by a recovery community organization or county, (2) a treatment
 95.28 plan if provided in either a substance use disorder treatment program under chapter 245G;
 95.29 or a Tribally licensed substance use disorder treatment program, or (3) a stabilization plan
 95.30 if provided by a withdrawal management program under chapter 245F.

96.1 (c) A client receiving peer recovery support services must participate in the services
 96.2 voluntarily. Any program that incorporates peer recovery support services must provide
 96.3 written notice to the client that peer recovery support services will be provided.

96.4 (d) Peer recovery support services may not be provided to a client residing with or
 96.5 employed by a recovery peer from whom ~~they receive~~ the client receives services.

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

96.7 Sec. 13. Minnesota Statutes 2024, section 254B.052, is amended by adding a subdivision
 96.8 to read:

96.9 **Subd. 7. Billing limits.** Eligible vendors of peer recovery support services must limit
 96.10 an individual client to 14 hours per week for peer recovery support services from an
 96.11 individual provider of peer recovery support services.

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

96.13 Sec. 14. Minnesota Statutes 2024, section 256B.0759, subdivision 3, is amended to read:

96.14 **Subd. 3. Provider standards.** ~~(a) The commissioner must establish requirements for~~
 96.15 ~~participating providers that are consistent with the federal requirements of the demonstration~~
 96.16 ~~project. The following programs that receive payment for substance use disorder treatment~~
 96.17 ~~services under section 256B.0625 must enroll as a Minnesota Health Care Programs provider,~~
 96.18 ~~meet the requirements established by the commissioner, and certify that the program meets~~
 96.19 ~~the applicable American Society of Addiction Medicine (ASAM) levels of care according~~
 96.20 ~~to section 254B.19:~~

96.21 (1) nonresidential substance use disorder treatment programs and residential treatment
 96.22 programs licensed under chapter 245G as licensed substance use disorder treatment facilities;

96.23 (2) withdrawal management programs licensed under chapter 245F; and

96.24 (3) out-of-state residential substance use disorder treatment programs.

96.25 Programs that do not meet the requirements of this paragraph are ineligible for payment for
 96.26 services provided under section 256B.0625.

96.27 ~~(b) A participating residential provider must obtain applicable licensure under chapter~~
 96.28 ~~245F or 245G or other applicable standards for the services provided and must:~~

96.29 ~~(1) deliver services in accordance with standards published by the commissioner pursuant~~
 96.30 ~~to paragraph (d);~~

97.1 ~~(2) maintain formal patient referral arrangements with providers delivering step-up or~~
 97.2 ~~step-down levels of care in accordance with ASAM standards; and~~

97.3 ~~(3) offer substance use disorder treatment services with medications for opioid use~~
 97.4 ~~disorder on site or facilitate access to substance use disorder treatment services with~~
 97.5 ~~medications for opioid use disorder off site.~~

97.6 ~~(e) A participating outpatient provider must obtain applicable licensure under chapter~~
 97.7 ~~245G or other applicable standards for the services provided and must:~~

97.8 ~~(1) deliver services in accordance with standards published by the commissioner pursuant~~
 97.9 ~~to paragraph (d); and~~

97.10 ~~(2) maintain formal patient referral arrangements with providers delivering step-up or~~
 97.11 ~~step-down levels of care in accordance with ASAM standards.~~

97.12 ~~(d) If the provider standards under chapter 245G or other applicable standards conflict~~
 97.13 ~~or are duplicative, the commissioner may grant variances to the standards if the variances~~
 97.14 ~~do not conflict with federal requirements. The commissioner must publish service~~
 97.15 ~~components, service standards, and staffing requirements for participating providers that~~
 97.16 ~~are consistent with ASAM standards and federal requirements by October 1, 2020.~~

97.17 (b) Programs licensed by the Department of Human Services as residential treatment
 97.18 programs according to section 245G.21 that (1) receive payment under this chapter, (2) are
 97.19 licensed as a hospital under sections 144.50 to 144.581, and (3) provide only ASAM level
 97.20 3.7 medically monitored inpatient level of care are not required to certify the ASAM 3.7
 97.21 level of care. If a program described in this paragraph provides any additional ASAM levels
 97.22 of care, the program must certify those levels of care according to section 254B.19. Programs
 97.23 meeting the criteria in this paragraph must submit evidence of providing the required level
 97.24 of care to the commissioner to be exempt from enrolling in the demonstration.

97.25 (c) Tribally licensed programs that otherwise meet the requirements of subdivision 3
 97.26 may elect to participate in the demonstration project. The Department of Human Services
 97.27 must consult with Tribal Nations to discuss participation in the substance use disorder
 97.28 demonstration project.

97.29 (d) Programs subject to this section must:

97.30 (1) deliver services in accordance with section 254B.19; and

97.31 (2) offer substance use disorder treatment services with medications for opioid use
 97.32 disorder on site or facilitate timely access to medications for opioid use disorder off site.

98.1 Sec. 15. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is
98.2 amended to read:

98.3 Subd. 4. **Provider payment rates.** ~~(a) Payment rates for participating Providers must~~
98.4 ~~be increased for services provided to medical assistance enrollees. To receive a rate increase,~~
98.5 ~~participating providers must meet demonstration project requirements and provide evidence~~
98.6 ~~of formal referral arrangements with providers delivering step-up or step-down levels of~~
98.7 ~~care. Providers that have enrolled in the demonstration project but have not met the provider~~
98.8 ~~standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under~~
98.9 ~~this subdivision until the date that the provider meets the provider standards in subdivision~~
98.10 ~~3. Services provided from July 1, 2022, to the date that the provider meets the provider~~
98.11 ~~standards under subdivision 3 shall be reimbursed at rates according to section 254B.0505,~~
98.12 ~~subdivision 1. Rate increases paid under this subdivision to a provider for services provided~~
98.13 ~~between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider~~
98.14 ~~is taking meaningful steps to meet demonstration project requirements that are not otherwise~~
98.15 ~~required by law, and the provider provides documentation to the commissioner, upon request,~~
98.16 ~~of the steps being taken.~~

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

98.21 ~~(c) For outpatient individual and group substance use disorder services under section~~
98.22 ~~254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed~~
98.23 ~~as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on~~
98.24 ~~or after January 1, 2021, payment rates must be increased by 20 percent over the rates in~~
98.25 ~~effect on December 31, 2020.~~

98.26 ~~(d)~~ (b) Effective January 1, 2021, and contingent on annual federal approval, managed
98.27 care plans and county-based purchasing plans must reimburse providers of the substance
98.28 use disorder services meeting the criteria described in paragraph (a) who requirements of
98.29 section 254B.19 that are employed by or under contract with the plan an amount that is at
98.30 least equal to the fee-for-service base rate payment for the substance use disorder services
98.31 described in paragraph ~~(e)~~ (a). The commissioner must monitor the effect of this requirement
98.32 on the rate of access to substance use disorder services and residential substance use disorder
98.33 rates. Capitation rates paid to managed care organizations and county-based purchasing
98.34 plans must reflect the impact of this requirement. This paragraph expires if federal approval
98.35 is not received at any time as required under this paragraph.

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

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

99.12 Sec. 16. **REPEALER.**

99.13 (a) Minnesota Statutes 2024, section 256B.0759, subdivisions 2 and 5, are repealed.

99.14 (b) Minnesota Statutes 2025 Supplement, section 254B.052, subdivision 6, is repealed.

99.15 **ARTICLE 4**

99.16 **DIRECT CARE AND TREATMENT POLICY**

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

99.18 **3.7381 LOSS, DAMAGE, OR DESTRUCTION OF PROPERTY; STATE** 99.19 **INSTITUTIONS; CORRECTIONAL FACILITIES.**

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

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

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

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

100.2 Subd. 4a. **Sex offender program data; challenges.** Notwithstanding subdivision 4,
100.3 challenges to the accuracy or completeness of data maintained by the Direct Care and
100.4 Treatment sex offender program about a civilly committed sex offender as defined in section
100.5 246B.01, subdivision 1a, must be submitted in writing to the data practices compliance
100.6 official of Direct Care and Treatment or a delegee. The data practices compliance official
100.7 or a delegee must respond to the challenge as provided in this section.

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

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

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

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

100.17 Sec. 4. Minnesota Statutes 2024, section 13.46, subdivision 1, is amended to read:

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

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

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

100.27 (c) "Welfare system" includes the Department of Human Services; Direct Care and
100.28 Treatment; the Department of Children, Youth, and Families; local social services agencies;
100.29 county welfare agencies; county public health agencies; county veteran services agencies;
100.30 county housing agencies; private licensing agencies; the public authority responsible for
100.31 child support enforcement; human services boards; community mental health center boards,
100.32 state hospitals, state nursing homes, the ombudsman for mental health and developmental

101.1 disabilities; Native American Tribes to the extent a Tribe provides a service component of
 101.2 the welfare system; and persons, agencies, institutions, organizations, and other entities
 101.3 under contract to any of the above agencies to the extent specified in the contract.

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

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

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

101.13 Sec. 5. Minnesota Statutes 2025 Supplement, section 13.46, subdivision 2, is amended to
 101.14 read:

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

101.17 (1) according to section 13.05;

101.18 (2) according to court order;

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

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

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

101.29 (6) to administer federal funds or programs;

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

102.1 (8) to the Department of Revenue to administer and evaluate tax refund or tax credit
102.2 programs and to identify individuals who may benefit from these programs, and prepare
102.3 the databases for reports required under section 270C.13 and Laws 2008, chapter 366, article
102.4 17, section 6. The following information may be disclosed under this paragraph: an
102.5 individual's and their dependent's names, dates of birth, Social Security or individual taxpayer
102.6 identification numbers, income, addresses, and other data as required, upon request by the
102.7 Department of Revenue. Disclosures by the commissioner of revenue to the commissioner
102.8 of human services for the purposes described in this clause are governed by section 270B.14,
102.9 subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent
102.10 care credit under section 290.067, the Minnesota working family credit under section
102.11 290.0671, the property tax refund under section 290A.04, and the Minnesota education
102.12 credit under section 290.0674;

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

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

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

102.20 (iii) to monitor and evaluate the Minnesota family investment program or the child care
102.21 assistance program by exchanging data on recipients and former recipients of Supplemental
102.22 Nutrition Assistance Program (SNAP) benefits, cash assistance under chapter 142F, 256D,
102.23 256J, or 256K, child care assistance under chapter 142E, medical programs under chapter
102.24 256B or 256L; and

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

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

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

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

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

103.13 (14) participant Social Security or individual taxpayer identification numbers and names
103.14 collected by the telephone assistance program may be disclosed to the Department of
103.15 Revenue to conduct an electronic data match with the property tax refund database to
103.16 determine eligibility under section 237.70, subdivision 4a;

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

103.20 (i) the participant:

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

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

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

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

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

103.31 (17) information obtained from a SNAP applicant or recipient households may be
103.32 disclosed to local, state, or federal law enforcement officials, upon their written request, for

104.1 the purpose of investigating an alleged violation of the Food and Nutrition Act, according
104.2 to Code of Federal Regulations, title 7, section 272.1(c);

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

104.7 (i) the member:

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

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

104.11 or

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

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

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

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

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

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

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

104.30 (23) to the Department of Education for the purpose of matching Department of Education
104.31 student data with public assistance data to determine students eligible for free and
104.32 reduced-price meals, meal supplements, and free milk according to United States Code,

105.1 title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state
105.2 funds that are distributed based on income of the student's family; and to verify receipt of
105.3 energy assistance for the telephone assistance plan;

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

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

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

105.16 (27) to monitor and evaluate the Minnesota family investment program by exchanging
105.17 data between the Departments of Human Services; Children, Youth, and Families; and
105.18 Education, on recipients and former recipients of SNAP benefits, cash assistance under
105.19 chapter 142F, 256D, 256J, or 256K, child care assistance under chapter 142E, medical
105.20 programs under chapter 256B or 256L, or a medical program formerly codified under chapter
105.21 256D;

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

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

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

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

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

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

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

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

106.14 (ii) to provide for reimbursement of special transportation service provided under section
106.15 473.386.

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

106.19 (b) Information on persons who have been treated for substance use disorder may only
106.20 be disclosed according to the requirements of Code of Federal Regulations, title 42, sections
106.21 2.1 to 2.67.

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

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

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

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

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

107.3 (h) Direct Care and Treatment may disclose welfare system data held by the agency to
107.4 facilitate coordination of guardianship services for Direct Care and Treatment clients,
107.5 including but not limited to making disclosures in guardianship proceedings, identifying
107.6 potential guardians, communicating with guardianship legal representation, and reporting
107.7 complaints to the Minnesota Judicial Branch or the Office of Ombudsman for Mental Health
107.8 and Developmental Disabilities. Direct Care and Treatment must obtain the client's consent
107.9 to the disclosure except when the client:

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

107.11 (2) has a current legal guardian who is unavailable, is nonresponsive, or refuses to
107.12 authorize the disclosure in relation to complaints to the Minnesota Judicial Branch or Office
107.13 of Ombudsman for Mental Health and Developmental Disabilities.

107.14 Sec. 6. Minnesota Statutes 2024, section 182.6545, is amended to read:

107.15 **182.6545 RIGHTS OF NEXT OF KIN UPON DEATH.**

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

107.18 (1) citations and notification of penalty;

107.19 (2) notices of hearings;

107.20 (3) complaints and answers;

107.21 (4) settlement agreements;

107.22 (5) orders and decisions; and

107.23 (6) notices of appeals.

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

108.1 **Sec. 7. [246C.051] CLASSIFICATION ALIGNMENT FOR DIRECT CARE AND**
 108.2 **TREATMENT EMPLOYEES.**

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

108.8 (b) Employees converted to the classified service pursuant to this section are subject to
 108.9 the terms and conditions of employment applicable to positions in the classified service
 108.10 pursuant to statute, rule, bargaining unit or compensation plan, and agency policy, including
 108.11 but not limited to required probationary periods and mandatory training requirements.

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

108.14 Sec. 8. Minnesota Statutes 2024, section 253B.03, subdivision 6, is amended to read:

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

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

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

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

108.26 (3) for a patient in a treatment facility, if the head of the treatment facility ~~or~~
 108.27 ~~state-operated treatment program~~ determines that the patient is not competent to consent to
 108.28 the treatment and the patient has not been adjudicated incompetent, written, informed consent
 108.29 for the ~~surgery or~~ medical treatment shall be obtained from the person appointed the health
 108.30 care power of attorney, the patient's agent under the health care directive, or the nearest
 108.31 proper relative. ~~For this purpose, the following persons are proper relatives, in the order~~
 108.32 ~~listed: the patient's spouse, parent, adult child, or adult sibling.~~ If the nearest proper relatives
 108.33 relative cannot be located, refuse refuses to consent to the procedure, or ~~are~~ is unable to

109.1 consent, the head of the treatment facility ~~or state-operated treatment program~~ or an interested
109.2 person, as defined by section 524.5-102, subdivision 7, may petition the committing court
109.3 for approval for the treatment or may petition a court of competent jurisdiction for the
109.4 appointment of a guardian. The determination that the patient is not competent, and the
109.5 reasons for the determination, shall be documented in the patient's clinical record;

109.6 (4) for patients in a state-operated treatment program, if (i) the patient does not have a
109.7 health care power of attorney or an agent under a health care directive or the patient's health
109.8 care agent is not reasonably available to make the necessary health care decision for the
109.9 patient, and (ii) the patient's treating physician determines that the patient lacks
109.10 decision-making capacity to consent to the medical treatment, the state-operated treatment
109.11 program must make a good faith attempt to locate the patient's nearest proper relative to
109.12 obtain written informed consent for the medical treatment;

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

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

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

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

110.1 (9) if a patient or interested person is dissatisfied with the outcome of the review under
 110.2 clause (8), the patient or interested person may petition the committing court under section
 110.3 253B.17 for review of the determination made under clause (8). Filing a petition under
 110.4 section 253B.17 does not stay treatment under this subdivision unless otherwise ordered by
 110.5 the court. In reviewing the executive medical director's decision under clause (8) and issuing
 110.6 a determination, the court must determine if the patient lacks capacity. If the patient lacks
 110.7 capacity, the court must determine if the patient clearly stated what the patient would choose
 110.8 to do in the situation when the patient had the capacity to make a reasoned decision. Evidence
 110.9 of the patient's wishes may include written instruments, including a durable power of attorney
 110.10 for health care under chapter 145C or a declaration under section 253B.03, subdivision 6d.
 110.11 If the court finds that the patient clearly stated what the patient would choose to do in the
 110.12 situation, the patient's wishes must be followed. If the court determines that the evidence
 110.13 of the patient's wishes regarding the situation is conflicting or lacking, the court must make
 110.14 a decision based on what a reasonable person would do, taking into consideration:

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

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

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

110.19 (iv) any other relevant factors;

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

110.22 ~~(4)~~ (11) consent to treatment of any minor patient shall be secured in accordance with
 110.23 sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization,
 110.24 routine diagnostic evaluation, and emergency or short-term acute care; and

110.25 ~~(5)~~ (12) in the case of an emergency when the persons ordinarily qualified to give consent
 110.26 cannot be located in sufficient time to address the emergency need, the head of the treatment
 110.27 facility or state-operated treatment program may give consent.

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

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

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

111.5 (2) the specific treatment authorized;

111.6 (3) the person who provided consent or who made the determination allowing the
111.7 treatment;

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

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

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

111.16 Sec. 9. Minnesota Statutes 2025 Supplement, section 253B.18, subdivision 6, is amended
111.17 to read:

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

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

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

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

111.29 (3) the need for continued institutionalization;

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

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

112.3 (c) If a committed person has been transferred out of a secure treatment facility pursuant
112.4 to this subdivision, that committed person may voluntarily return to a secure treatment
112.5 facility ~~for a period of up to 60 days~~ with the consent of the head of the treatment facility;
112.6 for a period of up to:

112.7 (1) 90 days if due to a psychiatric medical condition; or

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

112.9 (d) If the committed person is not returned to the original, nonsecure transfer facility
112.10 within ~~60~~ 90 days of being readmitted to a secure treatment facility if due to a psychiatric
112.11 medical condition or within six months of being readmitted to a secure treatment facility if
112.12 due to a nonpsychiatric medical condition, the transfer is revoked and the committed person
112.13 must remain in a secure treatment facility. The committed person must immediately be
112.14 notified in writing of the revocation.

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

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

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

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

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

112.29 (h) Upon the revocation of the transfer, the committed person must be immediately
112.30 returned to a secure treatment facility. A report documenting the reasons for revocation
112.31 must be issued by the head of the treatment facility within seven days after the committed
112.32 person is returned to the secure treatment facility. Advance notice to the committed person
112.33 of the revocation is not required.

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

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

113.8 (k) A committed person aggrieved by a transfer revocation decision may petition the
 113.9 special review board within seven business days after receipt of the revocation report for a
 113.10 review of the revocation. The matter must be scheduled within 30 days. The special review
 113.11 board shall review the circumstances leading to the revocation and, after considering the
 113.12 factors in paragraph (b), shall recommend to the executive board whether or not the
 113.13 revocation shall be upheld. The special review board may also recommend a new transfer
 113.14 out of a secure treatment facility at the time of the revocation hearing.

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

113.16 Sec. 10. Minnesota Statutes 2024, section 253B.18, subdivision 14, is amended to read:

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

113.20 (1) 30 days;~~or;~~

113.21 ~~(2) up to 60 90 days with the consent of the designated agency; if due to a psychiatric~~
 113.22 ~~medical condition; or~~

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

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

113.30 ~~(b)~~ (c) The treatment facility or state-operated treatment program is not required to
 113.31 petition for a further review by the special review board unless the patient's return to the
 113.32 community results in substantive change to the existing provisional discharge plan. All the

114.1 terms and conditions of the provisional discharge order shall remain unchanged if the patient
114.2 is released again.

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

114.4 **ARTICLE 5**

114.5 **DEPARTMENT OF HEALTH LONG-TERM CARE POLICY**

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

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

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

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

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

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

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

114.18 (i) the likelihood of the patient needing posthospital services and of the availability of
114.19 those services; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

115.29 ~~(3) until August 1, 2021, a housing with services establishment registered under chapter~~
 115.30 ~~144D that is either subject to chapter 144G or has a disclosed special unit under section~~
 115.31 ~~325F.72; or~~

116.1 ~~(4) on or after August 1, 2021, (3) licensed as an assisted living facility under chapter~~
 116.2 144G.

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

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

116.6 (1) a court-appointed guardian;

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

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

116.10 **Sec. 4. [144A.082] AUTOMATIC EXTERNAL DEFIBRILLATOR.**

116.11 (a) For purposes of this section, "automatic external defibrillator" has the meaning given
 116.12 in section 403.51, subdivision 1.

116.13 (b) A nursing home must:

116.14 (1) maintain an automatic external defibrillator in each building on the nursing home
 116.15 campus where residents may be present;

116.16 (2) ensure each automatic external defibrillator is maintained and regularly tested
 116.17 according to the manufacturer's recommendations; and

116.18 (3) as part of initial orientation and annually thereafter, ensure all nursing home personnel
 116.19 receive training in cardiopulmonary resuscitation, the use of automatic external defibrillators,
 116.20 the nursing home's process for checking a resident's code status before initiating lifesaving
 116.21 measures, and requesting emergency medical assistance as soon as practicable after an
 116.22 automatic external defibrillator is used.

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

116.24 **Sec. 5. [144A.104] PROHIBITED CONDITION FOR ADMISSION OR CONTINUED**
 116.25 **RESIDENCE.**

116.26 A nursing home is prohibited from requiring a current or prospective resident to have
 116.27 or obtain a guardian or conservator as a condition of admission to or continued residence
 116.28 in the nursing home.

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

117.1 Sec. 6. Minnesota Statutes 2024, section 144A.161, subdivision 1a, is amended to read:

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

117.7 Sec. 7. Minnesota Statutes 2024, section 144A.472, subdivision 5, is amended to read:

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

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

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

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

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

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

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

117.27 (c) Notwithstanding paragraph (b), a new owner of a home care provider business must
 117.28 ensure that employees of the provider receive and complete training and testing on any
 117.29 provisions of policies that differ from those of the previous owner within 90 days after the
 117.30 date of the change in ownership.

117.31 (d) After a change of ownership, the new licensee is responsible for any outstanding
 117.32 finances and any fines assessed following the effective date of the change of ownership.

118.1 Additionally, the new licensee is responsible for bringing the facility into compliance with
118.2 all existing ordered, imposed, or agreed-upon corrections and conditions.

118.3 Sec. 8. Minnesota Statutes 2025 Supplement, section 144A.474, subdivision 11, is amended
118.4 to read:

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

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

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

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

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

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

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

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

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

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

118.27 (1) level of violation:

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

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

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

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

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

119.9 (2) scope of violation:

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

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

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

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

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

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

119.31 (f) A license holder shall promptly notify the commissioner in writing when a violation
119.32 specified in the order is corrected. If upon reinspection the commissioner determines that

120.1 a violation has not been corrected as indicated by the order, the commissioner may issue a
 120.2 second fine. The commissioner shall notify the license holder by mail to the last known
 120.3 address in the licensing record that a second fine has been assessed. The license holder may
 120.4 appeal the second fine as provided under this subdivision.

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

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

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

120.15 (j) Fines collected under paragraph (a) shall be deposited in a dedicated special revenue
 120.16 account. On an annual basis, the balance in the special revenue account shall be appropriated
 120.17 to the commissioner to implement the recommendations of the advisory council established
 120.18 in section 144A.4799. The commissioner must publish on the department's website an annual
 120.19 report on the fines assessed and collected, and how the appropriated money was allocated.

120.20 Sec. 9. Minnesota Statutes 2024, section 144A.72, subdivision 2, is amended to read:

120.21 Subd. 2. **Penalties.** (a) Failure to comply with this section shall subject the supplemental
 120.22 nursing services agency to revocation or nonrenewal of its registration. Violations of section
 120.23 144A.74 are subject to a fine equal to 200 percent of the amount billed or received in excess
 120.24 of the maximum permitted under that section.

120.25 (b) The commissioner may request and must be given access to relevant information,
 120.26 records, incident reports, or other documents in the possession of a registered supplemental
 120.27 nursing services agency if considered necessary by the commissioner for verification
 120.28 purposes. If access is denied, the commissioner may bring enforcement action.

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

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

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

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

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

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

121.10 Sec. 12. Minnesota Statutes 2024, section 144G.08, is amended by adding a subdivision
121.11 to read:

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

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

121.14 (2) manual restraint, as defined in section 245D.02, subdivision 15a;

121.15 (3) mechanical restraint, as defined in section 245D.02, subdivision 15b; or

121.16 (4) any other form of restraint that limits the free and normal movement of body or
121.17 limbs.

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

121.19 Sec. 13. Minnesota Statutes 2024, section 144G.19, is amended by adding a subdivision
121.20 to read:

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

121.26 Sec. 14. Minnesota Statutes 2024, section 144G.31, subdivision 6, is amended to read:

121.27 Subd. 6. **Payment of fines required.** When a fine has been assessed, the licensee may
121.28 not avoid payment by closing, ~~selling, or otherwise transferring the license to a third party~~
121.29 the license. In such an event, the licensee shall be liable for payment of the fine. In the event

122.1 of a change of ownership, the new licensee is responsible for any outstanding fines and any
 122.2 fines assessed following the effective date of the change of ownership regardless of the date
 122.3 of the violation.

122.4 Sec. 15. Minnesota Statutes 2024, section 144G.40, subdivision 2, is amended to read:

122.5 Subd. 2. **Uniform checklist disclosure of information and services.** (a) All assisted
 122.6 living facilities must provide to prospective residents:

122.7 (1) a disclosure of the categories of assisted living licenses available and the category
 122.8 of license held by the facility;

122.9 (2) a written checklist listing all services permitted under the facility's license, identifying
 122.10 all services the facility offers to provide under the assisted living facility contract, and
 122.11 identifying all services allowed under the license that the facility does not provide; ~~and~~

122.12 (3) an oral explanation of the services offered under the contract;

122.13 (4) a copy of the most recent Department of Health survey of the facility;

122.14 (5) a list of all correction orders issued against and fines imposed on the facility in the
 122.15 previous three years and the results of all complaint investigations concerning the facility
 122.16 in the previous three years; and

122.17 (6) the website for the Department of Human Services and Board on Aging assisted
 122.18 living report card.

122.19 (b) The requirements of paragraph (a) must be completed prior to the execution of the
 122.20 assisted living contract.

122.21 (c) The commissioner must, in consultation with all interested stakeholders, design the
 122.22 uniform checklist disclosure form for use as provided under paragraph (a).

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

122.24 Sec. 16. Minnesota Statutes 2024, section 144G.41, subdivision 1, is amended to read:

122.25 Subdivision 1. **Minimum requirements.** All assisted living facilities shall:

122.26 (1) distribute to residents the assisted living bill of rights;

122.27 (2) provide services in a manner that complies with the Nurse Practice Act in sections
 122.28 148.171 to 148.285;

122.29 (3) utilize a person-centered planning and service delivery process;

123.1 (4) have and maintain a system for delegation of health care activities to unlicensed
123.2 personnel by a registered nurse, including supervision and evaluation of the delegated
123.3 activities as required by the Nurse Practice Act in sections 148.171 to 148.285;

123.4 (5) provide a means for residents to request assistance for health and safety needs 24
123.5 hours per day, seven days per week, and maintain a log of resident requests for assistance
123.6 and staff responses including, for each request, the time that elapsed between the resident's
123.7 communication of the request and the staff response. The facility must retain a log for at
123.8 least five years after the most recent request and response in the log;

123.9 (6) allow residents the ability to furnish and decorate the resident's unit within the terms
123.10 of the assisted living contract;

123.11 (7) permit residents access to food at any time;

123.12 (8) allow residents to choose the resident's visitors and times of visits;

123.13 (9) allow the resident the right to choose a roommate if sharing a unit;

123.14 (10) notify the resident of the resident's right to have and use a lockable door to the
123.15 resident's unit. The licensee shall provide the locks on the unit. Only a staff member with
123.16 a specific need to enter the unit shall have keys, and advance notice must be given to the
123.17 resident before entrance, when possible. An assisted living facility must not lock a resident
123.18 in the resident's unit;

123.19 (11) develop and implement a staffing plan for determining its staffing level that:

123.20 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness
123.21 of staffing levels in the facility;

123.22 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably
123.23 foreseeable unscheduled needs of each resident as required by the residents' assessments
123.24 and service plans on a 24-hour per day basis; and

123.25 (iii) ensures that the facility can respond promptly and effectively to individual resident
123.26 emergencies and to emergency, life safety, and disaster situations affecting staff or residents
123.27 in the facility;

123.28 (12) ensure that one or more persons are available 24 hours per day, seven days per
123.29 week, who are responsible for responding to the requests of residents for assistance with
123.30 health or safety needs. Such persons must be:

123.31 (i) awake;

124.1 (ii) located in the same building, in an attached building, or on a contiguous campus
 124.2 with the facility in order to respond within a reasonable amount of time;

124.3 (iii) capable of communicating with residents;

124.4 (iv) capable of providing or summoning the appropriate assistance; and

124.5 (v) capable of following directions; and

124.6 (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per
 124.7 week;

124.8 (14) ensure a plan to immediately attend to resident needs in a medical emergency is
 124.9 implemented; and

124.10 (15) ensure that a person trained in emergency medical response is on site 24 hours per
 124.11 day, seven days per week.

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

124.13 Sec. 17. Minnesota Statutes 2024, section 144G.41, subdivision 2, is amended to read:

124.14 Subd. 2. **Policies and procedures.** (a) Each assisted living facility must have policies
 124.15 and procedures in place to address the following ~~and keep them current~~:

124.16 (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;

124.17 (2) conducting and handling background studies on employees;

124.18 (3) orientation, training, and competency evaluations of staff, and a process for evaluating
 124.19 staff performance;

124.20 (4) handling complaints regarding staff or services provided by staff;

124.21 (5) conducting initial evaluations of residents' needs and the providers' ability to provide
 124.22 those services;

124.23 (6) conducting initial and ongoing resident evaluations and assessments of resident
 124.24 needs, including assessments by a registered nurse or appropriate licensed health professional,
 124.25 and how changes in a resident's condition are identified, managed, and communicated to
 124.26 staff and other health care providers as appropriate;

124.27 (7) orientation to and implementation of the assisted living bill of rights;

124.28 (8) infection control practices;

124.29 (9) reminders for medications, treatments, or exercises, if provided;

125.1 (10) conducting appropriate screenings, or documentation of prior screenings, to show
 125.2 that staff are free of tuberculosis, consistent with current United States Centers for Disease
 125.3 Control and Prevention standards;

125.4 (11) ensuring that nurses and licensed health professionals have current and valid licenses
 125.5 to practice;

125.6 (12) medication and treatment management;

125.7 (13) delegation of tasks by registered nurses or licensed health professionals;

125.8 (14) supervision of registered nurses and licensed health professionals; ~~and~~

125.9 (15) supervision of unlicensed personnel performing delegated tasks; and

125.10 (16) emergency medical procedures initiated when a resident is experiencing a medical
 125.11 emergency event, including but not limited to a resident falling, having a heart event, having
 125.12 difficulty breathing, bleeding, or choking.

125.13 (b) Each assisted living facility must keep all policies and procedures current and make
 125.14 them available to a resident or the resident's representative upon request. Policies and
 125.15 procedures covering emergency medical situations must be provided to prospective residents
 125.16 before admission to an assisted living facility and provided to current residents at the time
 125.17 of a nursing assessment as required under section 144G.70, subdivision 2.

125.18 Sec. 18. Minnesota Statutes 2024, section 144G.41, is amended by adding a subdivision
 125.19 to read:

125.20 Subd. 9. **Automatic external defibrillator.** (a) For purposes of this subdivision,
 125.21 "automatic external defibrillator" has the meaning given in section 403.51, subdivision 1.

125.22 (b) A facility must:

125.23 (1) maintain an automatic external defibrillator in each building on the assisted living
 125.24 facility campus where residents may be present; and

125.25 (2) ensure each automatic external defibrillator is maintained and regularly tested
 125.26 according to the manufacturer's recommendations.

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

126.1 Sec. 19. **[144G.505] PROHIBITED CONDITION OF ADMISSION OR CONTINUED**
126.2 **RESIDENCE.**

126.3 An assisted living facility is prohibited from requiring a current or prospective resident
126.4 to have or obtain a guardian or conservator as a condition of admission to or continued
126.5 residence in the assisted living facility.

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

126.7 Sec. 20. Minnesota Statutes 2024, section 144G.61, subdivision 2, is amended to read:

126.8 Subd. 2. **Training and evaluation of unlicensed personnel.** (a) Training and competency
126.9 evaluations for all unlicensed personnel must include the following:

126.10 (1) documentation requirements for all services provided;

126.11 (2) reports of changes in the resident's condition to the supervisor designated by the
126.12 facility;

126.13 (3) basic infection control, including blood-borne pathogens;

126.14 (4) maintenance of a clean and safe environment;

126.15 (5) appropriate and safe techniques in personal hygiene and grooming, including:

126.16 (i) hair care and bathing;

126.17 (ii) care of teeth, gums, and oral prosthetic devices;

126.18 (iii) care and use of hearing aids; and

126.19 (iv) dressing and assisting with toileting;

126.20 (6) training on the prevention of falls;

126.21 (7) standby assistance techniques and how to perform them;

126.22 (8) medication, exercise, and treatment reminders;

126.23 (9) basic nutrition, meal preparation, food safety, and assistance with eating;

126.24 (10) preparation of modified diets as ordered by a licensed health professional;

126.25 (11) communication skills that include preserving the dignity of the resident and showing
126.26 respect for the resident and the resident's preferences, cultural background, and family;

126.27 (12) awareness of confidentiality and privacy;

126.28 (13) understanding appropriate boundaries between staff and residents and the resident's
126.29 family;

- 127.1 (14) procedures to use in handling various emergency situations; ~~and~~
- 127.2 (15) awareness of commonly used health technology equipment and assistive devices;
- 127.3 and
- 127.4 (16) procedures to use in handling various emergency medical situations, including but
- 127.5 not limited to a resident falling, having a heart event, having difficulty breathing, bleeding,
- 127.6 or choking.
- 127.7 (b) In addition to paragraph (a), training and competency evaluation for unlicensed
- 127.8 personnel providing assisted living services must include:
- 127.9 (1) observing, reporting, and documenting resident status;
- 127.10 (2) basic knowledge of body functioning and changes in body functioning, injuries, or
- 127.11 other observed changes that must be reported to appropriate personnel;
- 127.12 (3) reading and recording temperature, pulse, and respirations of the resident;
- 127.13 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident;
- 127.14 (5) safe transfer techniques and ambulation;
- 127.15 (6) range of motioning and positioning; and
- 127.16 (7) administering medications or treatments as required.
- 127.17 Sec. 21. Minnesota Statutes 2024, section 144G.63, subdivision 2, is amended to read:
- 127.18 Subd. 2. **Content of required orientation.** (a) The orientation must contain the following
- 127.19 topics:
- 127.20 (1) an overview of this chapter;
- 127.21 (2) an introduction and review of the facility's policies and procedures related to the
- 127.22 provision of assisted living services by the individual staff person;
- 127.23 (3) handling of emergencies and use of emergency services;
- 127.24 (4) compliance with and reporting of the maltreatment of vulnerable adults under section
- 127.25 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
- 127.26 (5) the assisted living bill of rights and staff responsibilities related to ensuring the
- 127.27 exercise and protection of those rights;
- 127.28 (6) the principles of person-centered planning and service delivery and how they apply
- 127.29 to direct support services provided by the staff person;

128.1 (7) handling of residents' complaints, reporting of complaints, and where to report
128.2 complaints, including information on the Office of Health Facility Complaints;

128.3 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
128.4 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
128.5 Ombudsman at the Department of Human Services, county-managed care advocates, or
128.6 other relevant advocacy services; ~~and~~

128.7 (9) a review of the types of assisted living services the staff member will be providing
128.8 and the facility's category of licensure; and

128.9 (10) cardiopulmonary resuscitation, the use of automatic external defibrillators, the
128.10 facility's process for checking a resident's code status before initiating lifesaving measures,
128.11 and requesting emergency medical assistance as soon as practicable after an automatic
128.12 external defibrillator is used.

128.13 (b) In addition to the topics in paragraph (a), orientation may also contain training on
128.14 providing services to residents with hearing loss. Any training on hearing loss provided
128.15 under this subdivision must be high quality and research based, may include online training,
128.16 and must include training on one or more of the following topics:

128.17 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence,
128.18 and the challenges it poses to communication;

128.19 (2) health impacts related to untreated age-related hearing loss, such as increased
128.20 incidence of dementia, falls, hospitalizations, isolation, and depression; or

128.21 (3) information about strategies and technology that may enhance communication and
128.22 involvement, including communication strategies, assistive listening devices, hearing aids,
128.23 visual and tactile alerting devices, communication access in real time, and closed captions.

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

128.25 Sec. 22. Minnesota Statutes 2024, section 144G.63, subdivision 5, is amended to read:

128.26 Subd. 5. **Required annual training.** (a) All staff that perform direct services must
128.27 complete at least eight hours of annual training for each 12 months of employment. The
128.28 training may be obtained from the facility or another source and must include topics relevant
128.29 to the provision of assisted living services. The annual training must include:

128.30 (1) training on reporting of maltreatment of vulnerable adults under section 626.557;

128.31 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring
128.32 the exercise and protection of those rights;

129.1 (3) review of infection control techniques used in the home and implementation of
 129.2 infection control standards including a review of hand washing techniques; the need for and
 129.3 use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials
 129.4 and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable
 129.5 equipment; disinfecting environmental surfaces; and reporting communicable diseases;

129.6 (4) effective approaches to use to problem solve when working with a resident's
 129.7 challenging behaviors, and how to communicate with residents who have dementia,
 129.8 Alzheimer's disease, or related disorders;

129.9 (5) review of the facility's policies and procedures relating to the provision of assisted
 129.10 living services and how to implement those policies and procedures; ~~and~~

129.11 (6) the principles of person-centered planning and service delivery and how they apply
 129.12 to direct support services provided by the staff person; and

129.13 (7) cardiopulmonary resuscitation, the use of automatic external defibrillators, the
 129.14 facility's process for checking a resident's code status before initiating lifesaving measures,
 129.15 and requesting emergency medical assistance as soon as practicable after an automatic
 129.16 external defibrillator is used.

129.17 (b) In addition to the topics in paragraph (a), annual training may also contain training
 129.18 on providing services to residents with hearing loss. Any training on hearing loss provided
 129.19 under this subdivision must be high quality and research based, may include online training,
 129.20 and must include training on one or more of the following topics:

129.21 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence,
 129.22 and challenges it poses to communication;

129.23 (2) the health impacts related to untreated age-related hearing loss, such as increased
 129.24 incidence of dementia, falls, hospitalizations, isolation, and depression; or

129.25 (3) information about strategies and technology that may enhance communication and
 129.26 involvement, including communication strategies, assistive listening devices, hearing aids,
 129.27 visual and tactile alerting devices, communication access in real time, and closed captions.

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

129.29 Sec. 23. Minnesota Statutes 2024, section 144G.63, is amended by adding a subdivision
 129.30 to read:

129.31 **Subd. 5a. Orientation and annual training; other staff.** (a) All staff who are not subject
 129.32 to the orientation requirements in subdivisions 1 and 2 must complete an orientation on the

130.1 topics specified under paragraph (b) within 160 hours of the employment start date. All
 130.2 staff who are not subject to the annual training requirements in subdivision 5 must complete
 130.3 annual training on the topics specified under paragraph (b).

130.4 (b) The orientation and annual training must include training on cardiopulmonary
 130.5 resuscitation, the use of automatic external defibrillators, the facility's process for checking
 130.6 a resident's code status before initiating lifesaving measures, and requesting emergency
 130.7 medical assistance as soon as practicable after an automatic external defibrillator is used.

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

130.9 **Sec. 24. [144G.65] TRAINING IN EMERGENCY MANUAL RESTRAINTS.**

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

130.13 (1) types of behaviors and de-escalation techniques and their value;

130.14 (2) principles of person-centered planning and service delivery as identified in section
 130.15 245D.07, subdivision 1a, paragraph (b);

130.16 (3) what constitutes the use of a restraint;

130.17 (4) staff responsibilities related to: (i) prohibited procedures under section 144G.85; (ii)
 130.18 why prohibited procedures are not effective for reducing or eliminating symptoms or
 130.19 interfering behavior; and (iii) why prohibited procedures are not safe;

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

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

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

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

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

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

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

131.4 Sec. 25. **[144G.85] USE OF RESTRAINTS.**

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

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

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

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

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

131.17 (b) This section does not apply when a resident, or the resident's legal representative or
131.18 family member acting on the resident's behalf, chooses after being informed of the facility's
131.19 policy prohibiting the use of restraints to utilize a bed rail or other device that may constitute
131.20 a restraint. The facility must document that the resident, or the resident's representative or
131.21 family member acting on the resident's behalf, received information regarding the facility's
131.22 policy and the risks of using the device and voluntarily elected to utilize the device.

131.23 Subd. 3. **Documentation and notification.** (a) The resident's legal representative must
131.24 be notified within 24 hours of an emergency use of a manual restraint and of the
131.25 circumstances that prompted the use. Notification of an emergency use of a manual restraint
131.26 must be documented. If known, the advanced practice registered nurse, physician, or
131.27 physician assistant must be notified within 24 hours of an emergency use of a manual
131.28 restraint.

131.29 (b) On a form developed by the commissioner, the facility must notify the commissioner
131.30 and the ombudsman for long-term care within seven calendar days of an emergency use of
131.31 a manual restraint, including when any restraint is first applied or ordered. The commissioner

- 132.1 will monitor reported uses to detect overuse or unauthorized, inappropriate, or ineffective
132.2 use of the restraint. The form must include:
- 132.3 (1) the name and date of birth of the resident;
- 132.4 (2) the date and time of the use of the restraint;
- 132.5 (3) the names of staff and any residents who were involved in the incident leading up
132.6 to the emergency use of a manual restraint;
- 132.7 (4) a description of the incident, including the length of time the restraint was applied
132.8 and who was present before and during the incident leading up to the emergency use of a
132.9 manual restraint;
- 132.10 (5) a description of what less restrictive alternative measures were attempted to de-escalate
132.11 the incident and maintain safety that identifies when, how, and for how long the alternative
132.12 measures were attempted before the emergency use of a manual restraint was implemented;
- 132.13 (6) a description of the mental, physical, and emotional condition of the resident who
132.14 was restrained and of other persons involved in the incident leading up to, during, and
132.15 following the emergency use of a manual restraint;
- 132.16 (7) whether there was any injury to the resident who was restrained or other persons
132.17 involved in the incident, including staff, before or as a result of the emergency use of a
132.18 manual restraint; and
- 132.19 (8) whether there was a debriefing following the incident with the staff, and, if not
132.20 contraindicated, with the resident who was restrained and other persons who were involved
132.21 in or who witnessed the emergency use of a manual restraint, and the outcome of the
132.22 debriefing. If the debriefing was not conducted at the time the incident report was made,
132.23 the form should identify whether a debriefing is planned and a plan for mitigating use of
132.24 restraints in the future.
- 132.25 (c) A copy of the form submitted under paragraph (b) must be maintained in the resident's
132.26 record.
- 132.27 (d) A copy of the form submitted under paragraph (b) must be sent to the resident's
132.28 waiver case manager within seven calendar days of an emergency use of manual restraints.
132.29 An emergency use of manual restraints on people served under section 256B.49 and chapter
132.30 256S must be documented by the case manager in the resident's support plan, as defined in
132.31 sections 256B.49, subdivision 15, and 256S.10.

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

133.4 Subd. 4. **Ordered treatment.** Any use of a restraint, other than an emergency use of a
 133.5 manual restraint to address an imminent risk, must be the least restrictive option and comply
 133.6 with the requirements for an ordered treatment under section 144G.72.

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

133.8 Sec. 26. Minnesota Statutes 2024, section 157.17, subdivision 2, is amended to read:

133.9 Subd. 2. **Registration.** At the time of licensure or license renewal, a boarding and lodging
 133.10 establishment or a lodging establishment that provides supportive services or health
 133.11 supervision services must be registered with the commissioner, and must register annually
 133.12 thereafter. The registration must include the name, address, and telephone number of the
 133.13 establishment, the name of the operator, the types of services that are being provided, a
 133.14 description of the residents being served, the type and qualifications of staff in the facility,
 133.15 and other information that is necessary to identify the needs of the residents and the types
 133.16 of services that are being provided. The commissioner shall develop and furnish to the
 133.17 boarding and lodging establishment or lodging establishment the necessary form for
 133.18 submitting the registration.

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

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

133.22 ~~(2) the criminal background check requirements of sections 299C.66 to 299C.71 apply.~~

133.23 ~~The criminal background check requirements of section 144.057 apply only to personnel~~
 133.24 ~~providing home care services under sections 144A.43 to 144A.47 and personnel providing~~
 133.25 ~~hospice care under sections 144A.75 to 144A.755.~~

133.26 Sec. 27. Minnesota Statutes 2024, section 157.17, subdivision 5, is amended to read:

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

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

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

134.6 Sec. 28. Minnesota Statutes 2024, section 295.50, subdivision 4, is amended to read:

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

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

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

134.14 (3) a staff model health plan company;

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

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

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

134.22 (b) Health care provider does not include:

134.23 (1) hospitals; medical supplies distributors, except as specified under paragraph (a),
 134.24 clause (5); nursing homes licensed under chapter 144A or licensed in any other jurisdiction;
 134.25 wholesale drug distributors; pharmacies; surgical centers; bus and taxicab transportation,
 134.26 or any other providers of transportation services other than ambulance services required to
 134.27 be licensed; supervised living facilities for persons with developmental disabilities, licensed
 134.28 under Minnesota Rules, parts 4665.0100 to 4665.9900; ~~housing with services establishments~~
 134.29 ~~required to be registered under chapter 144D~~; board and lodging establishments providing
 134.30 only custodial services that are licensed under chapter 157 and registered under section
 134.31 157.17 to provide supportive services or health supervision services; adult foster homes as
 134.32 defined in Minnesota Rules, part 9555.5105; day training and habilitation services for adults

135.1 with developmental disabilities as defined in section 252.41, subdivision 3; boarding care
 135.2 homes, as defined in Minnesota Rules, part 4655.0100; and adult day care centers as defined
 135.3 in Minnesota Rules, part 9555.9600;

135.4 (2) home health agencies as defined in Minnesota Rules, part 9505.0175, subpart 15; a
 135.5 person providing personal care assistance services and supervision of personal care assistance
 135.6 services as defined in ~~Minnesota Rules, part 9505.0335~~ section 256B.0625, subdivision
 135.7 19a; a person providing home care nursing services as defined in Minnesota Rules, part
 135.8 9505.0360; and home care providers required to be licensed under chapter 144A for home
 135.9 care services provided under chapter 144A;

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

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

135.15 (5) a person who receives all payments for patient services from health care providers,
 135.16 surgical centers, or hospitals for goods and services that are taxable to the paying health
 135.17 care providers, surgical centers, or hospitals, as provided under section 295.53, subdivision
 135.18 1, paragraph (b), clause (3) or (4), or from a source of funds that is excluded or exempt from
 135.19 tax under sections 295.50 to 295.59.

135.20 Sec. 29. Minnesota Statutes 2025 Supplement, section 295.50, subdivision 9b, is amended
 135.21 to read:

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

135.25 (1) bed and board;

135.26 (2) nursing services and other related services;

135.27 (3) use of hospitals, surgical centers, or health care provider facilities;

135.28 (4) medical social services;

135.29 (5) drugs, biologicals, supplies, appliances, and equipment;

135.30 (6) other diagnostic or therapeutic items or services;

135.31 (7) medical or surgical services;

136.1 (8) items and services furnished to ambulatory patients not requiring emergency care;
136.2 and

136.3 (9) emergency services.

136.4 (b) "Patient services" does not include:

136.5 (1) services provided to nursing homes licensed under chapter 144A;

136.6 (2) examinations for purposes of utilization reviews, insurance claims or eligibility,
136.7 litigation, and employment, including reviews of medical records for those purposes;

136.8 (3) services provided to and by community residential mental health facilities licensed
136.9 under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by
136.10 residential treatment programs for children with a serious mental illness licensed or certified
136.11 under chapter 245A;

136.12 (4) services provided under the following programs: day treatment services as defined
136.13 in section 245.462, subdivision 8; assertive community treatment as described in section
136.14 256B.0622; adult rehabilitative mental health services as described in section 256B.0623;
136.15 crisis response services as described in section 256B.0624; and children's therapeutic services
136.16 and supports as described in section 256B.0943;

136.17 (5) services provided to and by community mental health centers as defined in section
136.18 245.62, subdivision 2;

136.19 (6) services provided to and by assisted living programs and congregate housing
136.20 programs;

136.21 (7) hospice care services;

136.22 (8) home and community-based waived services under chapter 256S and sections
136.23 256B.49 and 256B.501;

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

136.26 (10) services provided to the following: supervised living facilities for persons with
136.27 developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;
136.28 ~~housing with services establishments required to be registered under chapter 144D;~~ board
136.29 and lodging establishments providing only custodial services that are licensed under chapter
136.30 157 and registered under section 157.17 to provide supportive services or health supervision
136.31 services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training
136.32 and habilitation services for adults with developmental disabilities as defined in section

137.1 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100;
137.2 adult day care services as defined in section 245A.02, subdivision 2a; and home health
137.3 agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under
137.4 chapter 144A.

137.5 Sec. 30. **[340A.4015] NURSING HOMES, BOARDING CARE HOMES, AND**
137.6 **ASSISTED LIVING FACILITIES; WHEN LICENSE NOT REQUIRED.**

137.7 (a) A nursing home as defined in section 144A.01, subdivision 5, a boarding care home
137.8 as defined in Minnesota Rules, chapter 4655, or an assisted living facility as defined in
137.9 section 144G.08, subdivision 7, collectively known as "facility" or "facilities", is not required
137.10 to obtain a license or permit under this chapter for the service of intoxicating liquor on its
137.11 premise, subject to the following:

137.12 (1) the facility must submit notice to the commissioner of its intent to allow the service
137.13 of intoxicating liquor under this section;

137.14 (2) the facility must hold the license or licenses required by the commissioner of health
137.15 to be a valid licensed facility;

137.16 (3) intoxicating liquor may only be served to or by the residents of the facility and their
137.17 guests, when the guests are physically accompanied by a resident for the entirety of the
137.18 service;

137.19 (4) the service of intoxicating liquor may only occur at activities or events conducted
137.20 primarily for residents of the facility and their invited guests, and only within the licensed
137.21 facility or on its property;

137.22 (5) intoxicating liquor may not be sold, offered for sale, or otherwise provided for any
137.23 form of consideration; and

137.24 (6) facilities are subject to all other provisions and requirements of this chapter and its
137.25 applicable rules, not inconsistent with this section.

137.26 (b) A facility allowing the service of intoxicating liquor under this section is open for
137.27 inspection by the commissioner and the commissioner's representative and by peace officers,
137.28 who may enter and inspect during reasonable hours.

137.29 (c) Facilities operating under this section are subject to the requirements and penalties
137.30 outlined in section 340A.415 in the same manner as if they were a license or permit holder.

137.31 (d) The commissioner may take enforcement action as provided in section 340A.415
137.32 against any facility operating under this section for any violation of this section and any

138.1 other provision of this chapter and Minnesota Rules, chapter 7515, not inconsistent with
138.2 this section, including service to an obviously intoxicated person, unlawful furnishing,
138.3 underage access or consumption, unlawful possession, unlawful storage, or other
138.4 alcohol-related violations.

138.5 (e) The commissioner may prohibit service and require corrective action plans or
138.6 mandatory training for staff prior to a facility resuming operation under this section.

138.7 (f) The commissioner may refer any pattern of unsafe service, health risk associated
138.8 with alcohol service or storage, or failure to comply with this section to the commissioner
138.9 of health for investigation.

138.10 (g) Nothing in this section limits or otherwise affects criminal enforcement under this
138.11 chapter or any other law against a facility or any person.

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ARTICLE 1 CONTINUITY OF CARE..... Page.Ln 2.7
ARTICLE 2 AGING AND DISABILITY SERVICES POLICY..... Page.Ln 16.16
ARTICLE 3 SUBSTANCE USE DISORDER TREATMENT POLICY..... Page.Ln 88.32
ARTICLE 4 DIRECT CARE AND TREATMENT POLICY..... Page.Ln 99.15
ARTICLE 5 DEPARTMENT OF HEALTH LONG-TERM CARE POLICY..... Page.Ln 114.4

245A.04 APPLICATION PROCEDURES.

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043. At minimum, the license shall state:

- (1) the name of the license holder;
- (2) the address of the program;
- (3) the effective date and expiration date of the license;
- (4) the type of license and the specific service the license holder is licensed to provide;
- (5) the maximum number and ages of persons that may receive services from the program; and
- (6) any special conditions of licensure.

(b) The commissioner may issue a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the observation required by subdivision 4, paragraph (a), clause (3), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program.

(d) Except as provided in paragraphs (i) and (j), the commissioner shall not issue a license if the applicant, license holder, or an affiliated controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license under this chapter or chapter 142B within the past two years;

(3) had a license issued under this chapter or chapter 142B revoked within the past five years;

or

(4) failed to submit the information required of an applicant under subdivision 1, paragraph (f), (g), or (h), after being requested by the commissioner.

When a license issued under this chapter or chapter 142B is revoked, the license holder and each affiliated controlling individual with a revoked license may not hold any license under chapter 245A for five years following the revocation, and other licenses held by the applicant or license holder or licenses affiliated with each controlling individual shall also be revoked.

(e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license affiliated with a license holder or controlling individual that had a license revoked within the past five years if the commissioner determines that (1) the license holder or controlling individual is operating the program in substantial compliance with applicable laws and rules and (2) the program's continued operation is in the best interests of the community being served.

(f) Notwithstanding paragraph (d), the commissioner may issue a new license in response to an application that is affiliated with an applicant, license holder, or controlling individual that had an application denied within the past two years or a license revoked within the past five years if the commissioner determines that (1) the applicant or controlling individual has operated one or more programs in substantial compliance with applicable laws and rules and (2) the program's operation would be in the best interests of the community to be served.

(g) In determining whether a program's operation would be in the best interests of the community to be served, the commissioner shall consider factors such as the number of persons served, the availability of alternative services available in the surrounding community, the management structure of the program, whether the program provides culturally specific services, and other relevant factors.

(h) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

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(i) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

(j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

(k) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must comply with the requirements in section 245A.10 and be reissued a new license to operate the program or the program must not be operated after the expiration date. Adult foster care, family adult day services, child foster residence setting, and community residential services license holders must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

(l) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a Tribal licensing authority has established jurisdiction to license the program or service.

(m) The commissioner of human services may coordinate and share data with the commissioner of children, youth, and families to enforce this section.

(n) For substance use disorder treatment programs, for the purposes of paragraph (a), clause (5), the maximum number of persons who may receive services from the program includes persons served at satellite locations.

254B.052 PEER RECOVERY SUPPORT SERVICES REQUIREMENTS.

Subd. 6. **Monetary recovery.** Peer recovery support services not provided in accordance with this section are subject to monetary recovery under section 256B.064 as money improperly paid.

256B.051 HOUSING STABILIZATION SERVICES.

Subdivision 1. **Purpose.** Housing stabilization services are established to provide housing stabilization services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

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

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide housing stabilization services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section.

(c) "At-risk of homelessness" means (1) an individual that is faced with a set of circumstances likely to cause the individual to become homeless, or (2) an individual previously homeless, who will be discharged from a correctional, medical, mental health, or treatment center, who lacks sufficient resources to pay for housing and does not have a permanent place to live.

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

(e) "Employee of an agency" or "employee" means any person who is employed by an agency temporarily, part time, or full time and who performs work for at least 80 hours in a year for that agency in Minnesota. Employee does not include an independent contractor.

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(f) "Homeless" means an individual or family lacking a fixed, adequate nighttime residence.

(g) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria used by the title 11 program of the Social Security Act, United States Code, title 42, section 416, paragraph (i), item (1); or

(2) an individual who meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

(h) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause (3), and the Minnesota Security Hospital as defined in section 253.20.

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing stabilization services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has income at or below 150 percent of the federal poverty level;

(4) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(5) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301 (c); and

(6) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under chapter 256S or section 256B.092 or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, subdivisions 17 to 21, 23, 24, and 29 to 31, using a format established by the commissioner;

(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

Subd. 5. **Housing stabilization services.** (a) Housing stabilization services include housing transition services, housing and tenancy sustaining services, housing consultation services, and housing transition costs.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

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- (1) prevention and early identification of behaviors that may jeopardize continued stable housing;
- (2) education and training on roles, rights, and responsibilities of the tenant and the property manager;
- (3) coaching to develop and maintain key relationships with property managers and neighbors;
- (4) advocacy and referral to community resources to prevent eviction when housing is at risk;
- (5) assistance with housing recertification process;
- (6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and
- (7) continuing training on being a good tenant, lease compliance, and household management.

(d) Housing consultation services assist an individual with developing a person-centered plan when the individual is not eligible to receive person-centered planning through any other service.

(e) Housing transition costs are available to persons transitioning from a provider-controlled setting to the person's own home and include:

- (1) security deposits; and
- (2) essential furnishings and supplies.

Subd. 6. **Agency qualifications and duties.** An agency is eligible for reimbursement under this section only if the agency:

- (1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 6a;
- (2) is enrolled as a medical assistance Minnesota health care program provider and meets all applicable provider standards and requirements;
- (3) demonstrates compliance with federal and state laws and policies for housing stabilization services as determined by the commissioner;
- (4) complies with background study requirements under chapter 245C and maintains documentation of background study requests and results;
- (5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety bond of \$50,000. If the provider's medical assistance revenue in the previous year is over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;
- (6) directly provides housing stabilization services using employees of the agency and not by using a subcontractor or reporting agent;
- (7) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training; and
- (8) completes compliance training as required under subdivision 6b.

Subd. 6a. **Pre-enrollment risk assessment.** (a) Prior to enrolling a housing stabilization services agency, the commissioner must complete a pre-enrollment risk assessment of the agency seeking to enroll to confirm the agency's eligibility and the agency's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

- (1) the potential agency's history of performing services similar to those required by this section;
- (2) whether the services require the potential agency to perform duties at a significantly increased scale and, if so, whether the potential agency has the capability and organizational capacity to do so;
- (3) the potential agency's financial information and internal controls; and

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(4) the potential agency's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential agency does not have a history of performing similar duties, the potential agency does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential agency ineligible and deny or rescind enrollment. A potential agency may appeal a decision regarding its eligibility in writing within 30 business days. The commissioner must notify each potential agency of the commissioner's final decision regarding its eligibility.

(c) This subdivision is effective July 1, 2025. Any housing stabilization services provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Subd. 6b. Requirements for provider enrollment. (a) Effective January 1, 2027, to enroll as a housing stabilization services provider agency, an agency must require all owners of the agency who are active in the day-to-day management and operations of the agency and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

- (1) state and federal program billing, documentation, and service delivery requirements;
- (2) enrollment requirements;
- (3) provider program integrity, including fraud prevention, detection, and penalties;
- (4) fair labor standards;
- (5) workplace safety requirements; and
- (6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the agency. If an individual moves to another housing stabilization services provider agency and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any housing stabilization services provider agency enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

Subd. 7. Housing support supplemental service rates. Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing stabilization services under this section.

Subd. 8. Documentation requirements. (a) An agency must document delivery of all services. The agency must collect and maintain the required information either electronically or in paper form and must produce the documents containing the information upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

- (1) the full name of the service recipient;
- (2) the date the documentation occurred;
- (3) the day, month, and year the service was provided;

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(4) the start and stop times with a.m. and p.m. designations, except for housing consultation services;

(5) the service name or description of the service provided for each date of service;

(6) the name, signature, and title, if any, of the employee of the agency that provided the service. If the service is provided by multiple employees, the agency may designate an employee responsible for verifying services and completing the documentation required by this paragraph;

(7) the signature of the service recipient and a statement that the recipient's signature is verification of the accuracy of the service documentation; and

(8) a statement that it is a federal crime to provide false information on housing stabilization services billings for medical assistance payments.

Subd. 9. Service limits. (a) Housing stabilization services must not exceed the limits in clauses (1) to (4):

(1) housing transition services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing and tenancy sustaining services;

(2) housing and tenancy sustaining services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing transition services;

(3) housing consultation services are available once annually per recipient and must be provided in person. Additional sessions of housing consultation services may be authorized by the commissioner if the recipient becomes homeless, the recipient experiences a significant change in condition that impacts the recipient's housing, or the recipient requests an update or change to the recipient's plan; and

(4) housing transition costs are limited to \$3,000 annually.

(b) Remote support cannot be used for more than a total of 20 percent of all housing transition services and housing and tenancy sustaining services provided to a recipient in a calendar month and is limited to audio-only and accessible video-based platforms. A recipient may refuse, stop, or suspend the use of remote support at any time.

Subd. 10. Service limit exceptions. If a recipient requires services exceeding the limits described in subdivision 9, a provider may request authorization for additional hours in a format prescribed by the commissioner. Requests must specify the number of additional hours being requested to meet the recipient's needs and include sufficient documentation to justify the increase to billable hours. Exceptions to service limits are not allowed on the sole basis of changing providers and are limited to recipients who:

(1) become or are at risk of becoming homeless or institutionalized due to a significant change in condition;

(2) have a history of long-term homelessness;

(3) have a history of domestic violence; or

(4) have a criminal background that is a barrier to obtaining housing.

256B.0759 SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.

Subd. 2. Provider participation. (a) Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter, are licensed as a hospital under sections 144.50 to 144.581, and provide only ASAM 3.7 medically monitored inpatient level of care are not required to enroll as demonstration project providers. Programs meeting these criteria

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must submit evidence of providing the required level of care to the commissioner to be exempt from enrolling in the demonstration.

(d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(f) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with Tribal Nations to discuss participation in the substance use disorder demonstration project.

(g) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

(1) the provider attests that during the time period for which the provider is seeking the rate enhancement, the provider took meaningful steps in their plan approved by the commissioner to meet the demonstration project requirements in subdivision 3; and

(2) the provider submits attestation and evidence, including all information requested by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in a format required by the commissioner.

(h) The commissioner may recoup any rate enhancements paid under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

256B.5012 ICF/DD PAYMENT SYSTEM IMPLEMENTATION.

Subd. 4. **ICF/DD rate increases beginning July 1, 2001, and July 1, 2002.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 3.5 percent. Of this adjustment, two-thirds must be used as provided under paragraph (b) and one-third must be used for operating costs.

(b) The adjustment under this paragraph must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase must be used only for wage and benefit increases implemented on or after the first day of the rate year and must not be used for increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding June 30. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the payment rate adjustment provided under paragraph (b). The application must be made to the commissioner and contain a plan by which the facility will distribute the adjustment in paragraph (b) to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must

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submit its plan by March 31, 2002, and March 31, 2003, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Subd. 5. Rate increase effective June 1, 2003. For rate periods beginning on or after June 1, 2003, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by \$3 per day. The increase shall not be subject to any annual percentage increase.

Subd. 6. ICF/DD rate increases October 1, 2005, and October 1, 2006. (a) For the rate periods beginning October 1, 2005, and October 1, 2006, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 2.2553 percent.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except for administrative and central office employees. 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date. The wage adjustment eligible employees may receive may vary based on merit, seniority, or other factors determined by the provider.

(c) For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in paragraph (a) multiplied by the total payment rate, including variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the portion of the payment rate adjustment provided under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2006, and December 31, 2006, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Subd. 7. ICF/DD rate increases effective October 1, 2007, and October 1, 2008. (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2008. For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in this paragraph multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

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A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(b) Seventy-five percent of the money resulting from the rate adjustments under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the facility or exercises control over the facility; and

(3) persons paid by the facility under a management contract.

(c) Two-thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustments, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation-related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustments under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to facilities effective October 1 of each year.

(f) Facilities may apply for the portion of the rate adjustments under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustments, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustments. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in clause (1);

(3) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, email address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with requirements in clauses (1) to (4):

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the facility's payroll period that includes

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October 1 of each year shall be allowed if they were not used in the prior year's application and they meet the requirements of paragraphs (b) and (c);

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1 of the year in which the rate adjustments are effective and prior to April 1 of the following year; and

(4) for facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, as regards members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustments under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustments shall be effective October 1 of each year. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

Subd. 8. ICF/DD rate decreases effective July 1, 2009. Effective July 1, 2009, the commissioner shall decrease each facility reimbursed under this section operating payment adjustments equal to 2.58 percent of the operating payment rates in effect on June 30, 2009. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in subdivision 7.

Subd. 9. ICF/DD rate increase effective July 1, 2011; Clearwater County. Effective July 1, 2011, the commissioner shall increase the daily rate to \$138.23 at an intermediate care facility for the developmentally disabled located in Clearwater County and classified as a class A facility with 15 beds.

Subd. 10. ICF/DD rate decrease effective July 1, 2011; exception for Clearwater County. For each facility reimbursed under this section, except for a facility located in Clearwater County and classified as a class A facility with 15 beds, the commissioner shall decrease operating payment rates equal to 0.095 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 11. ICF/DD rate decrease effective July 1, 2011. For each facility reimbursed under this section, the commissioner shall decrease operating payments equal to 1.5 percent of the operating payment rates in effect on June 30, 2011. For each facility, the commissioner shall apply the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 12. ICF/DD rate increase effective July 1, 2013. For each facility reimbursed under this section, the commissioner shall increase operating payments equal to one-half percent of the operating payment rates in effect on June 30, 2013. For each facility, the commissioner shall apply the rate increase, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 14. Rate increase effective June 1, 2013. For rate periods beginning on or after June 1, 2013, the commissioner shall increase the total operating payment rate for each facility reimbursed

under this section by \$7.81 per day. The increase shall not be subject to any annual percentage increase.

Subd. 15. **ICF/DD rate increases effective April 1, 2014.** (a) Notwithstanding subdivision 12, for each facility reimbursed under this section, for the rate period beginning April 1, 2014, the commissioner shall increase operating payments equal to one percent of the operating payment rates in effect on March 31, 2014.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate, but excluding the property-related payment rate in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Subd. 16. **ICF/DD rate increases effective July 1, 2014.** (a) For the rate period beginning July 1, 2014, the commissioner shall increase operating payments for each facility reimbursed under this section equal to five percent of the operating payment rates in effect on June 30, 2014.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate in effect on June 30, 2014. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

(c) To receive the rate increase under paragraph (a), each facility reimbursed under this section must submit to the commissioner documentation that identifies a quality improvement project that the facility will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must:

- (1) improve the quality of life of intermediate care facility residents in a meaningful way;
- (2) improve the quality of services in a measurable way; or
- (3) deliver good quality service more efficiently while using the savings to enhance services for the participants served.

(d) For a facility that fails to submit the documentation described in paragraph (c) by a date or in a format specified by the commissioner, the commissioner shall reduce the facility's rate by one percent effective January 1, 2015.

(e) Facilities that receive a rate increase under this subdivision shall use 80 percent of the additional revenue to increase compensation-related costs for employees directly employed by the facility on or after July 1, 2014, except:

- (1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and
- (2) persons paid by the facility under a management contract.

This requirement is subject to audit by the commissioner.

(f) Compensation-related costs include:

- (1) wages and salaries;
- (2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;
- (3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and
- (4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (i).

(g) For public employees under a collective bargaining agreement, the increase for wages and benefits is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a facility under paragraph (e) for pay increases for public employees must be used only for pay increases implemented between July 1, 2014, and August 1, 2014.

(h) For a facility that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under

paragraph (i), in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the facility shall be deemed to have met all the requirements of this subdivision in regard to the members of the bargaining unit. Upon request, the facility shall produce the letter of acceptance for the commissioner.

(i) A facility that receives a rate adjustment under paragraph (a) that is subject to paragraph (e) shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the facility expects to receive that is subject to the requirements of paragraph (e), including how that money will be distributed to increase compensation for employees. The commissioner may recover funds from a facility that fails to comply with this requirement.

(j) By January 1, 2015, the facility shall post the distribution plan required under paragraph (i) for a period of at least six weeks in an area of the facility's operation to which all eligible employees have access and shall provide instructions for employees who do not believe they have received the wage and other compensation-related increases specified in the distribution plan. The instructions must include a mailing address, email address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative.

626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS.

Subd. 10. Duties of county social service agency. (a) When the common entry point refers a report to the county social service agency as the lead investigative agency or makes a referral to the county social service agency for emergency adult protective services, or when another lead investigative agency requests assistance from the county social service agency for adult protective services, the county social service agency shall immediately assess and offer emergency and continuing protective social services for purposes of preventing further maltreatment and for safeguarding the welfare of the maltreated vulnerable adult. The county shall use standardized tools and the data system made available by the commissioner. The information entered by the county into the standardized tool must be accessible to the Department of Human Services. In cases of suspected sexual abuse, the county social service agency shall immediately arrange for and make available to the vulnerable adult appropriate medical examination and treatment. When necessary in order to protect the vulnerable adult from further harm, the county social service agency shall seek authority to remove the vulnerable adult from the situation in which the maltreatment occurred. The county social service agency may also investigate to determine whether the conditions which resulted in the reported maltreatment place other vulnerable adults in jeopardy of being maltreated and offer protective social services that are called for by its determination.

(b) Within five business days of receipt of a report screened in by the county social service agency for investigation, the county social service agency shall determine whether, in addition to an assessment and services for the vulnerable adult, to also conduct an investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

(c) The county social service agency must investigate for a final disposition the individual or facility alleged to have maltreated a vulnerable adult for each report accepted as lead investigative agency involving an allegation of abuse, caregiver neglect that resulted in harm to the vulnerable adult, financial exploitation that may be criminal, or an allegation against a caregiver under chapter 256B.

(d) An investigating county social service agency must make a final disposition for any allegation when the county social service agency determines that a final disposition may safeguard a vulnerable adult or may prevent further maltreatment.

(e) If the county social service agency learns of an allegation listed in paragraph (c) after the determination in paragraph (a), the county social service agency must change the initial determination and conduct an investigation for final disposition of the individual or facility alleged to have maltreated the vulnerable adult.

(f) County social service agencies may enter facilities and inspect and copy records as part of an investigation. The county social service agency has access to not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, that are maintained by facilities to the extent necessary to conduct its investigation. The inquiry is not limited to the written records of the facility, but may include every other available source of information.

(g) When necessary in order to protect a vulnerable adult from serious harm, the county social service agency shall immediately intervene on behalf of that adult to help the family, vulnerable adult, or other interested person by seeking any of the following:

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(1) a restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(2) the appointment of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A;

(3) replacement of a guardian or conservator suspected of maltreatment and appointment of a suitable person as guardian or conservator, pursuant to sections 524.5-101 to 524.5-502; or

(4) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609.

The expenses of legal intervention must be paid by the county in the case of indigent persons, under section 524.5-502 and chapter 563.

In proceedings under sections 524.5-101 to 524.5-502, if a suitable relative or other person is not available to petition for guardianship or conservatorship, a county employee shall present the petition with representation by the county attorney. The county shall contract with or arrange for a suitable person or organization to provide ongoing guardianship services. If the county presents evidence to the court exercising probate jurisdiction that it has made a diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator. The county shall not retaliate against the employee for any action taken on behalf of the person subject to guardianship or conservatorship, even if the action is adverse to the county's interest. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and shall be entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

Laws 2025, First Special Session chapter 3, article 18, section 3

Sec. 3. **DIRECTION TO COMMISSIONER; INDIAN HEALTH SERVICE ENCOUNTER RATE.**

The commissioner of human services must submit a state plan amendment to the Centers for Medicare and Medicaid Services authorizing housing services as a new service category eligible for reimbursement at the outpatient per-day rate approved by the Indian Health Service. This reimbursement is limited to services provided by facilities of the Indian Health Service and facilities owned or operated by a Tribe or Tribal organization. For the purposes of this section, "housing services" means housing stabilization services as described in Minnesota Statutes, section 256B.051, subdivision 5, paragraphs (a) to (d).