SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 476

(SENATE AUTHORS: HOFFMAN, Utke, Abeler and Boldon)

DATE	D-PG	OFFICIAL STATUS
01/21/2025	141	Introduction and first reading
		Referred to Human Services
04/01/2025	1142a	Comm report: To pass as amended
	1243	Second reading
	6285	Rule 47, returned to Human Services
04/07/2026	7758a	Comm report: To pass as amended
	7904	Second reading
04/23/2026	9082a	Special Order: Amended
	9102	Third reading Passed as amended
05/12/2026	10412	Returned from House with amendment
	10413	Senate concurred and repassed bill
	10413	Third reading Passed as amended
		Presentment date 05/13/26
	11757	Governor's action Approval 05/14/26
	11758	Secretary of State Chapter 95 05/15/26
		Effective date various dates

A bill for an act

relating to state government; modifying provisions relating to Direct Care and Treatment, the Department of Health, aging and disability services, behavioral health services, housing and support services, maltreatment of vulnerable adults, and continuity of care; removing housing stabilization supports provisions; requiring release of Optum report; prohibiting Optum from disseminating private data; requiring rulemaking; requiring a report; amending Minnesota Statutes 2024, sections 3.7381; 13.04, subdivision 4a; 13.384, subdivision 3; 13.43, subdivision 5a; 13.46, subdivision 1, by adding a subdivision; 15.43, subdivision 3; 97B.001, subdivision 4; 144.121, subdivision 9; 144.56, subdivision 2b; 144.586, subdivision 2; 144.6502, subdivision 1; 144.6512, subdivision 6; 144A.161, subdivisions 1a, 8; 144A.472, subdivision 5; 144A.72, subdivision 2; 144G.08, by adding subdivisions; 144G.19, by adding a subdivision; 144G.31, subdivision 6; 144G.40, subdivision 2; 144G.41, subdivisions 1, 2, by adding a subdivision; 144G.60, subdivision 4; 144G.61, subdivision 2; 144G.92, subdivision 5; 152.137, subdivision 6; 157.17, subdivisions 2, 5; 182.6545; 245.991, subdivision 3; 245.992, subdivisions 1, 2; 245A.03, by adding subdivisions; 245A.11, subdivision 2a; 245D.04, subdivision 3, by adding a subdivision; 245D.09, subdivision 5; 245D.10, subdivision 3; 245F.02, subdivision 17; 245F.15, subdivision 7; 245G.04, by adding a subdivision; 245G.06, subdivision 4; 245G.11, subdivision 8; 245I.10, subdivision 6; 253B.03, subdivisions 2, 3, 6, by adding a subdivision; 253B.18, subdivision 14; 253D.19, subdivision 1; 254B.052, subdivision 1, by adding a subdivision; 256.9752, as amended; 256B.04, subdivision 24, by adding subdivisions; 256B.057, subdivision 9; 256B.0623, subdivision 6; 256B.0624, subdivisions 6b, 7; 256B.0625, subdivisions 4, 47, by adding a subdivision; 256B.0658; 256B.0759, subdivision 3; 256B.0911, subdivision 32; 256B.0924, subdivisions 3, 5, 7, by adding a subdivision; 256B.0943, subdivision 6, by adding a subdivision; 256B.0946, subdivision 4; 256B.0947, subdivision 5; 256B.0949, by adding a subdivision; 256B.4905, subdivision 2a; 256B.492, subdivisions 1, 3; 256B.493, subdivision 1; 256B.851, subdivision 8; 256D.54, subdivision 1; 256L.03, subdivision 1; 256R.481; 256S.205, subdivision 1; 256S.21, subdivision 3; 295.50, subdivision 4; 524.5-409, subdivision 2; 626.557, subdivisions 9, 9a, 12b, by adding subdivisions; 626.5572, subdivisions 2, 9, 17, by adding subdivisions; Minnesota Statutes 2025 Supplement, sections 13.46, subdivision 2; 15.471, subdivision 6; 144.121, subdivision 1a; 144A.474, subdivision 11; 144A.4799, subdivision 1; 245.469, subdivision 1; 245.4889, subdivision 1; 245C.03, subdivision 6; 245C.04, subdivision 6; 245C.10, subdivision 6; 245D.091, subdivisions 2, 3; 245D.10, subdivision 3a; 245F.08, subdivision 3; 245G.09,

subdivision 3; 245G.11, subdivision 7; 245I.04, subdivision 17; 253B.18, subdivision 6; 254A.03, subdivision 3; 254B.04, subdivision 1a; 254B.0501, subdivision 6; 254B.0505, subdivision 8, by adding subdivisions; 256B.04, subdivision 21; 256B.0625, subdivision 5m; 256B.0701, subdivision 9; 256B.0759, subdivision 4; 256B.0911, subdivision 13; 256B.0924, subdivision 6; 256B.0943, subdivisions 1, 9; 256B.0947, subdivision 3a; 256B.0949, subdivisions 2, 16, 18; 256B.4914, subdivision 10a; 256L.03, subdivision 5; 256S.205, subdivision 2; 295.50, subdivision 9b; 524.5-311; 626.5572, subdivision 13; Laws 2023, chapter 61, article 1, section 67, subdivision 3, as amended; article 9, section 2, subdivision 5, as amended; Laws 2024, chapter 125, article 1, section 47; article 4, section 12, subdivision 5; article 8, section 2, subdivisions 4, 14, as amended, 20; proposing coding for new law in Minnesota Statutes, chapters 144A; 144G; 245; 245D; 246C; 253B; repealing Minnesota Statutes 2024, sections 245A.03, subdivision 7; 256B.051, subdivisions 1, 4, 7; 256B.0759, subdivisions 2, 5; 256B.5012, subdivisions 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16; 626.557, subdivision 10; Minnesota Statutes 2025 Supplement, sections 254B.052, subdivision 6; 256B.051, subdivisions 2, 3, 5, 6, 6a, 6b, 8, 9, 10; Laws 2025, First Special Session chapter 3, article 18, section 3.

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

ARTICLE 1

DIRECT CARE AND TREATMENT POLICY

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

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

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

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

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

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

Subd. 4a. **Sex offender program data; challenges.** Notwithstanding subdivision 4, challenges to the accuracy or completeness of data maintained by the Direct Care and

Treatment sex offender program about a civilly committed sex offender as defined in section 246B.01, subdivision 1a, must be submitted in writing to the data practices compliance official of Direct Care and Treatment or a delegee. The data practices compliance official or a delegee must respond to the challenge as provided in this section.

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

Subd. 3. **Classification of medical data.** Unless the data is summary data or a statute specifically provides a different classification, medical data are private but are available only to the subject of the data as provided in sections 144.291 to 144.298, and shall not be disclosed to others except:

(a) pursuant to ~~section~~ sections 13.05 and 13.46;

(b) pursuant to section 253B.0921;

(c) pursuant to a valid court order;

(d) to administer federal funds or programs;

(e) to the surviving spouse, parents, children, siblings, and health care agent of a deceased patient or client or, if there are no surviving spouse, parents, children, siblings, or health care agent to the surviving heirs of the nearest degree of kindred;

(f) to communicate a patient's or client's condition to a family member, health care agent, or other appropriate person in accordance with acceptable medical practice, unless the patient or client directs otherwise; or

(g) as otherwise required by law.

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

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

(1) place where previous education or training occurred;

(2) place of prior employment; and

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

EFFECTIVE DATE. This section is effective the day following final enactment and applies to any data request pending on or received after that date.

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

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

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

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

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

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

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

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

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

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

(1) according to section 13.05;

(2) according to court order;

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

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

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

(6) to administer federal funds or programs;

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

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

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

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

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

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

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

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

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

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

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

(14) participant Social Security or individual taxpayer identification numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

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

(i) the participant:

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

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

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

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

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

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

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

(i) the member:

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

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

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

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

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

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

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

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

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

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

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

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks,

federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Direct Care and Treatment may disclose data as provided in subdivision 14.

Sec. 7. Minnesota Statutes 2024, section 13.46, is amended by adding a subdivision to read:

Subd. 14. **Direct Care and Treatment.** (a) Notwithstanding sections 144.291 to 144.298, Direct Care and Treatment may disclose data pursuant to subdivision 2 and as otherwise permitted by law.

(b) Direct Care and Treatment may disclose welfare system data held by the agency to facilitate guardianship proceedings for Direct Care and Treatment clients, and for reporting complaints to the Minnesota Judicial Branch or the Office of Ombudsman for Mental Health and Developmental Disabilities. Direct Care and Treatment must obtain the client's consent for a disclosure made pursuant to this paragraph except when the client:

(1) lacks capacity to provide the consent; or

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

Sec. 8. Minnesota Statutes 2024, section 182.6545, is amended to read:

182.6545 RIGHTS OF NEXT OF KIN UPON DEATH.

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

(1) citations and notification of penalty;

(2) notices of hearings;

(3) complaints and answers;

(4) settlement agreements;

(5) orders and decisions; and

(6) notices of appeals.

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

Sec. 9. **[246C.051] CLASSIFICATION ALIGNMENT FOR DIRECT CARE AND TREATMENT EMPLOYEES.**

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

(b) Employees converted to the classified service pursuant to this section are subject to the terms and conditions of employment applicable to positions in the classified service pursuant to statute, rule, bargaining unit or compensation plan, and agency policy, including but not limited to required probationary periods and mandatory training requirements.

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

Sec. 10. Minnesota Statutes 2024, section 253B.03, subdivision 2, is amended to read:

Subd. 2. **Correspondence.** A patient has the right to correspond freely without censorship, subject to section 253B.25. The head of the treatment facility or head of the state-operated treatment program may restrict correspondence if the patient's medical welfare requires this restriction. For a patient in a state-operated treatment program, that determination may be reviewed by the executive board. Any limitation imposed on the exercise of a patient's correspondence rights and the reason for it shall be made a part of the clinical record of the patient. Any communication which is not delivered to a patient shall be immediately returned to the sender.

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

Sec. 11. Minnesota Statutes 2024, section 253B.03, subdivision 3, is amended to read:

Subd. 3. **Visitors and phone calls.** Subject to the general rules of the treatment facility or state-operated treatment program and section 253B.25, a patient has the right to receive visitors and make phone calls. The head of the treatment facility or head of the state-operated treatment program may restrict visits and phone calls on determining that the medical welfare of the patient requires it. Any limitation imposed on the exercise of the patient's visitation and phone call rights and the reason for it shall be made a part of the clinical record of the patient.

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

Sec. 12. Minnesota Statutes 2024, section 253B.03, subdivision 6, is amended to read:

Subd. 6. **Consent for medical procedure.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) notwithstanding section 253B.02, subdivision 10, "interested person" has the meaning given under section 524.5-102, subdivision 7;

(2) notwithstanding section 253B.02, subdivision 15, "patient" includes a person committed under chapter 253D who is in a state-operated treatment program; and

(3) "proper relative" means, in the following order, the patient's spouse, parent, adult child, or adult sibling.

(b) A patient has the right to give prior consent to any medical ~~or surgical~~ treatment, including but not limited to surgery, other than treatment for chemical dependency or nonintrusive treatment for mental illness.

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

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

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

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

(4) for patients in a state-operated treatment program, if (i) the patient does not have a health care power of attorney or an agent under a health care directive or the patient's health care agent is not reasonably available to make the necessary health care decision for the patient, and (ii) the patient's treating physician determines that the patient lacks decision-making capacity to consent to the medical treatment, the state-operated treatment program must make a good faith attempt to locate the patient's nearest proper relative to obtain written informed consent for the medical treatment;

(5) if the state-operated treatment program is unable to reasonably locate a proper relative, the executive medical director has decision-making authority for the health care decision for the patient subject to the provisions under subdivision 6e;

(6) if the state-operated treatment program consults with the patient's nearest proper relative under clause (4) and the patient's nearest proper relative and the patient's treating

physician are not in agreement with respect to a medical treatment decision, the state-operated treatment program or an interested person may petition the committing court for approval of the treatment. The state-operated treatment program may also petition a court of competent jurisdiction for the appointment of a guardian at any time. If a court determines that a patient is not competent, the determination and the reasons for the determination must be documented in the patient's clinical record;

~~(4)~~ (7) consent to treatment of any minor patient shall be secured in accordance with sections 144.341 to 144.346. A minor 16 years of age or older may consent to hospitalization, routine diagnostic evaluation, and emergency or short-term acute care; and

~~(5)~~ (8) in the case of an emergency when the persons ordinarily qualified to give consent cannot be located in sufficient time to address the emergency need, the head of the treatment facility or state-operated treatment program may give consent.

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

Sec. 13. Minnesota Statutes 2024, section 253B.03, is amended by adding a subdivision to read:

Subd. 6e. **Health care decisions made by executive medical director.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) notwithstanding section 253B.02, subdivision 10, "interested person" has the meaning given under section 524.5-102, subdivision 7; and

(2) notwithstanding section 253B.02, subdivision 15, "patient" includes a person committed under chapter 253D who is in a state-operated treatment program.

(b) Any health care decision made by the executive medical director under subdivision 6, paragraph (c), clause (5), must be consistent with any documented patient health care directive and with reasonable medical practice and applicable law.

(c) Before proceeding with treatment under subdivision 6, paragraph (c), clause (5), a state-operated treatment program must inform the patient of the determination by the patient's treating physician that the patient lacks decision-making capacity to consent to the medical treatment, the proposed treatment, and the right to request review. Upon the request of the patient or an interested person a second physician not directly involved in the patient's

current treatment must review the incapacity determination. The executive medical director must review the proposed treatment decision and the second physician's review of the incapacity determination and make an updated determination. A state-operated treatment program may proceed with treatment of the patient while a review under this paragraph is pending.

(d) When a determination is made under paragraph (c), the state-operated treatment program must document the following information in the patient's clinical record:

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

(2) the specific treatment authorized;

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

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

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

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

(f) If a patient or interested person is dissatisfied with the outcome of the review under paragraph (c), the patient or interested person may petition the committing court under section 253B.17 for review of the incapacity determination made under paragraph (c). Filing a petition under section 253B.17 does not stay treatment under this subdivision unless otherwise ordered by the court. In reviewing the executive medical director's decision under paragraph (c) and issuing a determination, the court must determine if the patient lacks capacity. If the patient lacks capacity, the court must determine if the patient clearly stated what the patient would choose to do in the situation when the patient had the capacity to make a reasoned decision. Evidence of the patient's wishes may include written instruments, including a durable power of attorney for health care under chapter 145C or a declaration under section 253B.03, subdivision 6d. If the court finds that the patient clearly stated what the patient would choose to do in the situation, the patient's wishes must be followed. If the court determines that the evidence of the patient's wishes regarding the situation are

conflicting or lacking, the court must make a decision based on what a reasonable person would do, taking into consideration:

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

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

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

(4) any other relevant factors.

Sec. 14. Minnesota Statutes 2025 Supplement, section 253B.18, subdivision 6, is amended to read:

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

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

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

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

(3) the need for continued institutionalization;

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

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

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

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

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

(d) If the committed person is not returned to the original, nonsecure transfer facility within ~~60~~ 90 days of being readmitted to a secure treatment facility if due to a psychiatric medical condition or within six months of being readmitted to a secure treatment facility if due to a nonpsychiatric medical condition, the transfer is revoked and the committed person must remain in a secure treatment facility. The committed person must immediately be notified in writing of the revocation.

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

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

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

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

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

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

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

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

(k) A committed person aggrieved by a transfer revocation decision may petition the special review board within seven business days after receipt of the revocation report for a review of the revocation. The matter must be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and, after considering the factors in paragraph (b), shall recommend to the executive board whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure treatment facility at the time of the revocation hearing.

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

Sec. 15. Minnesota Statutes 2024, section 253B.18, subdivision 14, is amended to read:

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

(1) 30 days~~, or~~;

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

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

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

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

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

Sec. 16. **[253B.25] PATIENT ACCESS TO INFORMATION ON FACILITY EMPLOYEES.**

The head of a treatment facility or state-operated treatment program may restrict patient access to correspondence and telephone calls that the head of the facility reasonably believes will be used to harass, intimidate, or assault employees of the treatment facility or state-operated treatment program.

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

Sec. 17. Minnesota Statutes 2024, section 253D.19, subdivision 1, is amended to read:

Subdivision 1. **Limited rights.** The executive board may limit the statutory rights described in subdivision 2 for persons committed to the Minnesota Sex Offender Program under this chapter or with the executive board's consent under section 246C.13. The statutory rights described in subdivision 2 may be limited only as necessary to maintain a therapeutic environment or the security of the facility or to protect the safety and well-being of committed persons, staff, and the public. Protection of staff from harassment, intimidation, or assault is a basis for limiting the statutory rights described in subdivision 2.

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

ARTICLE 2
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2024, section 15.43, subdivision 3, is amended to read:

Subd. 3. **Other exemptions.** The ~~commissioners~~ commissioner of ~~human services and~~ corrections and Direct Care and Treatment executive board may by rule prescribe procedures for the acceptance of gifts from any person or organization, provided that such gifts are accepted by the commissioner or executive board, or a designated representative of the commissioner or executive board, and that such gifts are used solely for the direct benefit of patients, clients, or inmates under the jurisdiction of the accepting state officer.

Sec. 2. Minnesota Statutes 2025 Supplement, section 144.121, subdivision 1a, is amended to read:

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

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

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

(c) For purposes of this section, a security screening system means ionizing radiation-producing equipment designed and used for security screening of humans who are in the custody of a correctional or detention facility or who are civilly committed in a secure treatment facility, and used by the facility to image and identify contraband items concealed within or on all sides of a human body.

(d) For purposes of this section, a correctional or detention facility is a facility licensed under section 241.021 and operated by a state agency or political subdivision charged with detection, enforcement, or incarceration in respect to state criminal and traffic laws.

(e) For purposes of this section, a secure treatment facility includes the facilities listed in sections 253B.02, subdivision 18a, and 253D.02, subdivision 13.

(f) The commissioner shall adopt rules to establish requirements for the use of security screening systems. Notwithstanding section 14.125, the authority to adopt these rules does not expire.

Sec. 3. Minnesota Statutes 2024, section 144.121, subdivision 9, is amended to read:

Subd. 9. **Exemption from examination requirements; operators of security screening systems.** (a) An employee of a correctional ~~or~~, detention, or secure treatment facility who operates a security screening system and the facility in which the system is being operated are exempt from the requirements of subdivisions 5 and 6.

(b) An employee of a correctional or detention facility who operates a security screening system and the facility in which the system is being operated must meet the requirements of a variance to Minnesota Rules, parts 4732.0305 and 4732.0565, issued under Minnesota

Rules, parts 4717.7000 to 4717.7050. This paragraph expires on December 31 of the year that the permanent rules adopted by the commissioner governing security screening systems are published in the State Register.

(c) An employee of a secure treatment facility who operates a security screening system and the facility in which the system is being operated must meet the requirements of a variance to Minnesota Rules, parts 4732.0305 and 4732.0565, issued under Minnesota Rules, parts 4717.7000 to 4717.7050.

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

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

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

Sec. 5. Laws 2024, chapter 125, article 8, section 2, subdivision 20, is amended to read:

Subd. 20. **Direct Care and Treatment - Operations**	-0-	6,094,000

(a) **Free Communication Services for Patients and Clients.** $1,368,000 in fiscal year 2025 is for free communication services under article 6, section 1. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2026.

(b) **Direct Care and Treatment Capacity; Miller Building.** $1,796,000 in fiscal year 2025 is to design a replacement facility for the Miller Building on the Anoka Metro Regional Treatment Center campus. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(c) **Direct Care and Treatment County Correctional Facility Support Pilot Program.** $2,387,000 in fiscal year 2025 is to establish a two-year county correctional facility support pilot program. The pilot program must: (1) provide education and support to counties and county correctional facilities on protocols and best practices for the provision of involuntary medications for mental health treatment; (2) provide technical assistance to expand access to injectable psychotropic medications in county correctional facilities; and (3) survey county correctional facilities and their contracted medical providers on their capacity to provide injectable psychotropic medications, including involuntary administration of medications, and barriers to providing these services. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, ~~2026~~ 2028.

(d) **Advisory Committee for Direct Care and Treatment.** $482,000 in fiscal year 2025 is for the administration of the advisory committee for the operation of Direct Care and Treatment. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, ~~2027~~ 2028.

(e) **Base Level Adjustment.** The general fund base is increased by $31,000 in fiscal year 2026 and increased by $0 in fiscal year 2027.

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

ARTICLE 3
DEPARTMENT OF HEALTH POLICY

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

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

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

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

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

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

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

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

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

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

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

(4) providing counseling, as needed, for the patient and family members or interested persons to prepare them for posthospital care. The hospital must provide a list of available Medicare-eligible home care agencies or skilled nursing facilities that serve the patient's geographic area, or other area requested by the patient if such care or placement is indicated

and appropriate. Once the patient has designated their preferred providers, the hospital will assist the patient in securing care covered by their health plan or within the care network. The hospital must not specify or otherwise limit the qualified providers that are available to the patient. The hospital must document in the patient's record that the list was presented to the patient or to the individual acting on the patient's behalf.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) a court-appointed guardian;

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

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

Sec. 4. **[144A.104] PROHIBITED CONDITION FOR ADMISSION OR CONTINUED RESIDENCE.**

(a) A nursing home is prohibited from requiring a current or prospective resident to have or obtain a guardian or conservator as a condition of admission to or continued residence in the nursing home.

(b) Nothing in this section may be construed to prohibit, limit, or otherwise affect section 524.5-303 or 524.5-403.

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

Sec. 5. Minnesota Statutes 2024, section 144A.161, subdivision 1a, is amended to read:

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

Sec. 6. Minnesota Statutes 2024, section 144A.472, subdivision 5, is amended to read:

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

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

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

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

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

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

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

(c) Notwithstanding paragraph (b), a new owner of a home care provider business must ensure that employees of the provider receive and complete training and testing on any provisions of policies that differ from those of the previous owner within 90 days after the date of the change in ownership.

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

Sec. 7. Minnesota Statutes 2025 Supplement, section 144A.474, subdivision 11, is amended to read:

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

(1) Level 1, no fines or enforcement;

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

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

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

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

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

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

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

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

(1) level of violation:

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

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

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

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

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

(2) scope of violation:

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

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

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

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

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

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

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

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

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

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

(j) Fines collected under paragraph (a) shall be deposited in a dedicated special revenue account. ~~On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.~~ Money deposited in the account is appropriated to the commissioner

on an annual basis for a competitive grant program for special projects for improving home care client quality of care and outcomes in Minnesota, with a specific focus on workforce and clinical outcomes, including projects consistent with the criteria in section 144A.4799, subdivision 3, paragraph (c). Grants must be distributed to home care providers licensed under this chapter or organizations with experience in or knowledge of home care operations, compliance, client needs, or best practices. Each grant must be at least $1,000. The commissioner may retain up to ten percent of the amount available to cover the costs to administer the grant under this section. The commissioner must publish on the department's website an annual report on the fines assessed and collected, and how the appropriated money was allocated.

Sec. 8. Minnesota Statutes 2025 Supplement, section 144A.4799, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

(b) When a vacancy occurs for an appointment identified in paragraph (a), the commissioner must select an applicant for appointment within 81 calendars days of the position being posted by the secretary of state if the application of a qualified and, if applicable, a licensee in good standing applicant is received within 21 days of posting. If no qualified applications are received within the first 21 days, the commissioner must select an applicant for appointment within 60 calendar days of receiving the application of a qualified and, if applicable, a licensee in good standing applicant.

Sec. 9. Minnesota Statutes 2024, section 144A.72, subdivision 2, is amended to read:

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

(b) The commissioner may request and must be given access to relevant information, records, incident reports, or other documents in the possession of a registered supplemental nursing services agency if considered necessary by the commissioner for verification purposes. If access is denied, the commissioner may bring enforcement action.

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

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

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

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

Subd. 54a. **Prone restraint.** "Prone restraint" means the use of manual restraint that places a resident in a face-down position. Prone restraint does not include the brief physical holding of a resident who, during an emergency use of a manual restraint, rolls into a prone

position and as quickly as possible the resident is restored to a standing, sitting, or side-lying position.

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

Sec. 12. Minnesota Statutes 2024, section 144G.08, is amended by adding a subdivision to read:

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

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

(2) manual restraint, as defined in section 245D.02, subdivision 15a;

(3) mechanical restraint, as defined in section 245D.02, subdivision 15b; or

(4) any other form of restraint that limits the free and normal movement of body or limbs.

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

Sec. 13. Minnesota Statutes 2024, section 144G.19, is amended by adding a subdivision to read:

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

Sec. 14. Minnesota Statutes 2024, section 144G.31, subdivision 6, is amended to read:

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

Sec. 15. Minnesota Statutes 2024, section 144G.40, subdivision 2, is amended to read:

Subd. 2. **Uniform checklist disclosure of services.** (a) All assisted living facilities must provide to prospective residents:

(1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility;

(2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, ~~and~~ identifying all services allowed under the license that the facility does not provide, and beginning August 1, 2027, including notification that the facility's most recent plan of correction is available, according to section 144G.30, subdivision 5, paragraph (d), and the website for the Department of Human Services and Board on Aging assisted living report card; and

(3) an oral explanation of the services offered under the contract.

(b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.

(c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).

Sec. 16. Minnesota Statutes 2024, section 144G.41, subdivision 1, is amended to read:

Subdivision 1. **Minimum requirements.** All assisted living facilities shall:

(1) distribute to residents the assisted living bill of rights;

(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;

(3) utilize a person-centered planning and service delivery process;

(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;

(5) except as specified in subdivision 1c, provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week. A facility may use person-centered strategies to provide a means for residents to request assistance and, if effective, may allow residents to use technological devices to request assistance;

(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;

(7) permit residents access to food at any time;

(8) allow residents to choose the resident's visitors and times of visits;

(9) allow the resident the right to choose a roommate if sharing a unit;

(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;

(11) develop and implement a staffing plan for determining its staffing level that:

(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;

(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and

(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;

(12) effective until the effective date of clause (14), ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;

(iii) capable of communicating with residents;

(iv) capable of providing or summoning the appropriate assistance; and

(v) capable of following directions; ~~and~~

(13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week;

(14) effective August 1, 2027, ensure that one or more persons who are trained in accordance with section 144G.61, subdivision 2, are available 24 hours per day, seven days per week, and are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;

(iii) capable of communicating with residents;

(iv) capable of providing or summoning the appropriate assistance; and

(v) capable of following directions;

(15) effective August 1, 2027, ensure a plan is in place for facility staff to immediately attend to resident needs in a medical emergency until any emergency personnel arrive, if summoned; and

(16) effective August 1, 2027, ensure a plan is in place for facility staff to meet the nonemergency medical needs of residents due to falling, including needs for lift assistance.

Sec. 17. Minnesota Statutes 2024, section 144G.41, is amended by adding a subdivision to read:

Subd. 1c. **Alternative to summoning device to request assistance.** For a resident who, based on an individualized nursing assessment under section 144G.70, subdivision 2, cannot reliably use a summoning device such as a phone, bell, call light, pull cord, or pendant to request assistance for health and safety needs, a facility:

(1) is not required to have a resident use a summoning device to request assistance for health and safety needs; and

(2) must use person-centered strategies to meet the resident's assessed needs.

Sec. 18. Minnesota Statutes 2024, section 144G.41, subdivision 2, is amended to read:

Subd. 2. **Policies and procedures.** (a) Each assisted living facility must have policies and procedures in place to address the following ~~and keep them current~~:

(1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;

(2) conducting and handling background studies on employees;

(3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;

(4) handling complaints regarding staff or services provided by staff;

(5) conducting initial evaluations of residents' needs and the providers' ability to provide those services;

(6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;

(7) orientation to and implementation of the assisted living bill of rights;

(8) infection control practices;

(9) reminders for medications, treatments, or exercises, if provided;

(10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;

(11) ensuring that nurses and licensed health professionals have current and valid licenses to practice;

(12) medication and treatment management;

(13) delegation of tasks by registered nurses or licensed health professionals;

(14) supervision of registered nurses and licensed health professionals; ~~and~~

(15) supervision of unlicensed personnel performing delegated tasks;

(16) effective August 1, 2027, emergency procedures to be initiated by facility staff when a resident experiences a medical emergency due to falling, a heart event, difficulty breathing, or choking, and to be followed until emergency personnel arrive, if summoned; and

(17) effective August 1, 2027, after determining that a resident is not experiencing a medical emergency pursuant to clause (16), procedures to be initiated by facility staff to meet the nonemergency medical needs of residents due to falling, including needs for lift assistance.

(b) Beginning August 1, 2027, each assisted living facility must keep all policies and procedures current and make them available to a resident or the resident's representative upon request. Policies and procedures covering medical emergency events under paragraph (a), clause (16), must be provided to prospective residents for whom a prospective resident assessment has been performed as described under section 144G.70, subdivision 2, paragraph (b), but before signing an assisted living contract, and to current residents upon any changes to the policies and procedures covering medical emergencies under paragraph (a), clause (16).

Sec. 19. **[144G.505] PROHIBITED CONDITION OF ADMISSION OR CONTINUED RESIDENCE.**

(a) An assisted living facility is prohibited from requiring a current or prospective resident to have or obtain a guardian or conservator as a condition of admission to or continued residence in the assisted living facility.

(b) Nothing in this section may be construed to prohibit, limit, or otherwise affect section 524.5-303 or 524.5-403.

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

Sec. 20. Minnesota Statutes 2024, section 144G.60, subdivision 4, is amended to read:

Subd. 4. **Unlicensed personnel.** (a) Unlicensed personnel providing assisted living services must have:

(1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or

(2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), ~~and~~ (8), and (20), by a practical skills test.

Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks.

(b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:

(1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) ~~and~~, (7), and (20), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;

(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or

(3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.

(c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks in section 144G.62, subdivision 2, paragraph (a), and any other training or competency requirements within the licensed health professional's scope of practice relating to delegation or assignment of tasks to unlicensed personnel.

Sec. 21. Minnesota Statutes 2024, section 144G.61, subdivision 2, is amended to read:

Subd. 2. **Training and evaluation of unlicensed personnel.** (a) Training and competency evaluations for all unlicensed personnel must include the following:

(1) documentation requirements for all services provided;

(2) reports of changes in the resident's condition to the supervisor designated by the facility;

(3) basic infection control, including blood-borne pathogens;

(4) maintenance of a clean and safe environment;

(5) appropriate and safe techniques in personal hygiene and grooming, including:

(i) hair care and bathing;

(ii) care of teeth, gums, and oral prosthetic devices;

(iii) care and use of hearing aids; and

(iv) dressing and assisting with toileting;

(6) training on the prevention of falls;

(7) standby assistance techniques and how to perform them;

(8) medication, exercise, and treatment reminders;

(9) basic nutrition, meal preparation, food safety, and assistance with eating;

(10) preparation of modified diets as ordered by a licensed health professional;

(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;

(12) awareness of confidentiality and privacy;

(13) understanding appropriate boundaries between staff and residents and the resident's family;

(14) effective until the effective date of clause (15), procedures to use in handling various emergency situations; ~~and~~

(15) effective August 1, 2027, procedures to use in handling various medical and nonmedical emergency situations;

~~(15)~~ (16) awareness of commonly used health technology equipment and assistive devices;

(17) effective August 1, 2027, recognition of and immediate response to signs and symptoms of airway, breathing, and circulation concerns;

(18) effective August 1, 2027, recognition of and immediate response to bleeding, including hemorrhage;

(19) effective August 1, 2027, safe techniques for emergency movement of residents; and

(20) effective August 1, 2027, log roll technique and spinal precautions.

(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:

(1) observing, reporting, and documenting resident status;

(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;

(3) reading and recording temperature, pulse, and respirations of the resident;

(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;

(5) safe transfer techniques and ambulation;

(6) range of motioning and positioning; and

(7) administering medications or treatments as required.

Sec. 22. **[144G.65] TRAINING IN EMERGENCY MANUAL RESTRAINTS.**

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

(1) types of behaviors and de-escalation techniques and their value;

(2) principles of person-centered planning and service delivery as identified in section 245D.07, subdivision 1a, paragraph (b);

(3) what constitutes the use of a restraint;

(4) staff responsibilities related to: (i) prohibited procedures under section 144G.85; (ii) why prohibited procedures are not effective for reducing or eliminating symptoms or interfering behavior; and (iii) why prohibited procedures are not safe;

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

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

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

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

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

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

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

Sec. 23. **[144G.85] USE OF RESTRAINTS.**

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

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

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

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

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

(b) This section does not apply when a resident or the resident's legal representative chooses, after being informed of the facility's policy prohibiting the use of restraints, to utilize a bed rail or other device that may constitute a restraint. The facility must document that the resident or the resident's representative received information regarding the facility's policy and the risks of using the device and voluntarily elected to utilize the device.

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

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

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

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

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

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

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

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

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

(8) whether there was a debriefing following the incident with the staff, and, if not contraindicated, with the resident who was restrained and other persons who were involved in or who witnessed the emergency use of a manual restraint, and the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the form should identify whether a debriefing is planned and a plan for mitigating use of restraints in the future.

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

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

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

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

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

Sec. 24. Minnesota Statutes 2024, section 157.17, subdivision 2, is amended to read:

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

boarding and lodging establishment or lodging establishment the necessary form for submitting the registration.

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

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

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

Sec. 25. Minnesota Statutes 2024, section 157.17, subdivision 5, is amended to read:

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

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

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

Sec. 26. Minnesota Statutes 2024, section 295.50, subdivision 4, is amended to read:

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

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

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

(3) a staff model health plan company;

(4) an ambulance service required to be licensed;

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

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

(b) Health care provider does not include:

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

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

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

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

(5) a person who receives all payments for patient services from health care providers, surgical centers, or hospitals for goods and services that are taxable to the paying health

care providers, surgical centers, or hospitals, as provided under section 295.53, subdivision 1, paragraph (b), clause (3) or (4), or from a source of funds that is excluded or exempt from tax under sections 295.50 to 295.59.

Sec. 27. Minnesota Statutes 2025 Supplement, section 295.50, subdivision 9b, is amended to read:

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

(1) bed and board;

(2) nursing services and other related services;

(3) use of hospitals, surgical centers, or health care provider facilities;

(4) medical social services;

(5) drugs, biologicals, supplies, appliances, and equipment;

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

(8) items and services furnished to ambulatory patients not requiring emergency care; and

(9) emergency services.

(b) "Patient services" does not include:

(1) services provided to nursing homes licensed under chapter 144A;

(2) examinations for purposes of utilization reviews, insurance claims or eligibility, litigation, and employment, including reviews of medical records for those purposes;

(3) services provided to and by community residential mental health facilities licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by residential treatment programs for children with a serious mental illness licensed or certified under chapter 245A;

(4) services provided under the following programs: day treatment services as defined in section 245.462, subdivision 8; assertive community treatment as described in section 256B.0622; adult rehabilitative mental health services as described in section 256B.0623;

crisis response services as described in section 256B.0624; and children's therapeutic services and supports as described in section 256B.0943;

(5) services provided to and by community mental health centers as defined in section 245.62, subdivision 2;

(6) services provided to and by assisted living programs and congregate housing programs;

(7) hospice care services;

(8) home and community-based waivered services under chapter 256S and sections 256B.49 and 256B.501;

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

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

Sec. 28. **SPECIAL PROJECTS GRANT PROGRAM FOR HOME CARE PROVIDERS.**

By December 31, 2028, the commissioner of health must distribute the balance as of January 1, 2027, in the special revenue account under Minnesota Statutes, section 144A.474, subdivision 11, paragraph (j), under a competitive grant program for special projects for improving home care client quality of care and outcomes in Minnesota, with a specific focus on workforce and clinical outcomes, including projects consistent with criteria in Minnesota Statutes, section 144A.4799, subdivision 3, paragraph (c). Grants must be distributed to home care providers licensed under Minnesota Statutes, chapter 144A, or organizations with experience in or knowledge of home care operations, compliance, client needs, or best practices. Each grant must be at least $1,000. Any amount that has not been awarded as a

grant by December 31, 2028, must be used for the annual distributions under Minnesota Statutes, section 144A.474, subdivision 11, paragraph (j), beginning January 1, 2029.

ARTICLE 4
AGING AND DISABILITY SERVICES POLICY

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

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

(b) The commissioner shall not issue an initial license for adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If an adult foster care home license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to Minnesota Statutes 2016, section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings. Residential settings that would otherwise be subject to the decreased license capacity established in this paragraph must be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(c) The commissioner shall not issue an initial license for a community residential setting licensed under this chapter and chapter 245D. When an adult resident served by the program moves out of an adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for community residential settings. Residential settings that would otherwise be subject to the decreased license capacity established in this paragraph

must be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

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

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

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

(b) When approving an exception under this subdivision to the foster care or community residential setting moratorium described in subdivision 7b, the commissioner shall consider the resource need determination process in subdivision 7d, the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of the person's choices during the person's annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal.

(c) Permissible exceptions to the moratorium include:

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

(2) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under subdivision 7d for the closure of a nursing facility, an intermediate care facility for individuals with developmental disabilities, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or movement to the community of people who no longer require the level of care

provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24; and

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

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

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

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

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

(d) License holders of foster care homes identified under paragraph (c) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as

authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

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

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

Sec. 4. Minnesota Statutes 2024, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (h).

(b) The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a facility with a licensed capacity of up to five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(d) The commissioner may grant variances to paragraph (a) to allow the use of an additional bed, up to six, for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with

section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of an additional bed, up to six, for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the facility; and

(4) individuals living in the facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before March 1, 2016.

(g) The commissioner shall not issue a new adult foster care license under paragraph (f) after December 31, 2020. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before December 31, 2020, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (f).

(h) The commissioner may ~~issue an adult foster care or community residential setting license with a capacity of five or six adults to facilities meeting the criteria in section 245A.03, subdivision 7, paragraph (a), clause (5), and~~ grant variances to paragraph (b) to allow the facility to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(i) Notwithstanding Minnesota Rules, part 9520.0500, adult foster care and community residential setting licenses with a capacity of up to six adults as allowed under this subdivision are not required to be licensed as an adult mental health residential program according to Minnesota Rules, parts 9520.0500 to 9520.0670.

Sec. 5. Minnesota Statutes 2025 Supplement, section 245C.03, subdivision 6, is amended to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities ~~and providers of housing stabilization services~~.** (a) For providers of services specified in the federally approved home and community-based waiver plans under section 256B.4912 ~~and providers of housing stabilization services under section 256B.051~~, the commissioner shall conduct background studies on any individual who is an owner with at least a five percent ownership stake in the provider, an operator of the provider, or an employee or volunteer for the provider who has direct contact with people receiving the services. The individual studied must meet the

requirements of this chapter prior to providing waiver services and as part of ongoing enrollment.

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

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

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

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

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

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

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

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

(2) the individual who is the subject of the background study provides direct contact services under the provider's licensed program for at least 40 hours per year so the individual will be recognized by a probation officer or corrections agent to prompt a report to the

commissioner regarding criminal convictions as required under section 245C.05, subdivision 7.

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

Sec. 7. Minnesota Statutes 2025 Supplement, section 245C.10, subdivision 6, is amended to read:

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

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

Sec. 8. Minnesota Statutes 2024, section 245D.09, subdivision 5, is amended to read:

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

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

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

Sec. 9. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 2, is amended to read:

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

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

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

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

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

(11) demonstrated expertise with populations being served; and

(12) must be a:

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

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

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

(iv) licensed professional clinical counselor licensed under sections ~~148B.29 to 148B.39~~ 148B.50 to 148B.75 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

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

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

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

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

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

Sec. 10. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2024, section 256.9752, as amended by Laws 2025, First Special Session chapter 9, article 1, sections 6 and 7, is amended to read:

256.9752 SENIOR NUTRITION PROGRAMS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) medically tailored meals;

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

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

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

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

Sec. 12. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E. A provider must enroll each provider-controlled location where direct services are provided. The commissioner may deny a provider's incomplete application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request. The commissioner must conduct a background study under chapter 245C, including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider described in this paragraph. The background study requirement may be satisfied if the commissioner conducted a fingerprint-based background study on the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

(b) The commissioner shall revalidate:

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

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

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

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

(c) The commissioner shall conduct revalidation as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) serves primarily a pediatric population.

(j) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a

list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

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

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

Sec. 14. Minnesota Statutes 2024, section 256B.0658, is amended to read:

256B.0658 HOUSING ACCESS GRANTS.

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

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

(b) "Individual with a disability" means:

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

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

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

Sec. 15. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended to read:

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

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

(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;~~

(3) demonstrates compliance with federal and state laws and policies for recuperative care 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) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training;

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

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

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

Sec. 16. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 13, is amended to read:

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

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

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

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

(3) be a registered nurse.

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

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

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

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

Sec. 17. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

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

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

(2) provide the services in this section; and

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2024, section 256B.0924, subdivision 3, is amended to read:

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

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

(1) be age 18 or older;

(2) be receiving medical assistance;

(3) have significant functional limitations; and

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

(b) Except as permitted under paragraph (c), the person must be: (1) a vulnerable adult in need of adult protection as defined in section 626.5572~~, or is~~; (2) an adult with a developmental disability as defined in section 252A.02, subdivision 2~~, or~~; (3) an adult with

a related condition as defined in section 256B.02, subdivision 11, ~~and~~ who is not receiving home and community-based waiver services~~,~~; or ~~is~~ (4) an adult who lacks a permanent residence and who has been without a permanent residence for at least one year or on at least four occasions in the last three years.

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

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

Sec. 19. Minnesota Statutes 2024, section 256B.0924, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

(8) have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management service

provider also provides the recipient's services and supports and provides information on all potential conflicts of interest and obtains the recipient's informed consent and provides the recipient with alternatives; and

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

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

Sec. 20. Minnesota Statutes 2024, section 256B.0924, is amended by adding a subdivision to read:

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

Sec. 21. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is amended to read:

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

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

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2. Payment for case management provided by vendors who contract with a Tribe must be made in accordance with Indian Health Service facility requirements. If a Tribe chooses to contract with a vendor receiving payment not through an Indian Health Service facility, the rate must be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or Tribe, except to reimburse the county or Tribe for advance funding provided by the county or Tribe to the vendor.

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

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

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

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

(h) Payments to counties and Tribes for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this

section. Payments to contracted vendors shall include both the federal earnings and the county share.

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

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

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

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

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

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

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

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

Sec. 22. Minnesota Statutes 2024, section 256B.0924, subdivision 7, is amended to read:

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

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

Sec. 23. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 2, is amended to read:

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

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

(c) "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 EIDBI services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section. Agency includes a licensed individual professional who practices independently and acts as an agency.

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

(1) is severe and chronic;

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

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

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

(i) behavioral challenges and self-regulation;

(ii) cognition;

(iii) learning and play;

(iv) self-care; or

(v) safety.

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

(f) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including ~~individual treatment planning,~~ staff supervision, including observation and direction; individual treatment plan development and progress monitoring~~,~~; family training and counseling; and ~~treatment review~~ coordinated care conference coordination for each person. Clinical supervision is provided by a qualified supervising professional (QSP) who takes full professional responsibility for the service provided by each supervisee and the clinical effectiveness of all interventions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 18, is amended to read:

Subd. 18. **Site visits and sanctions.** (a) The commissioner may conduct unannounced on-site inspections of any and all EIDBI agencies and service locations to verify that information submitted to the commissioner is accurate, determine compliance with all enrollment requirements, investigate reports of maltreatment, determine compliance with

service delivery and billing requirements, and determine compliance with any other applicable laws or rules.

(b) The commissioner may withhold payment from an agency or suspend or terminate the agency's enrollment number if the agency fails to provide access to the agency's service locations or records or fails to comply with documentation requirements under subdivision 19 or the commissioner determines the agency has failed to comply fully with applicable laws or rules. The provider has the right to appeal the decision of the commissioner under section 256B.064.

Sec. 26. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision to read:

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

(b) All documentation must:

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

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

(3) be signed and dated by the provider completing the documentation with the provider's full name, title, and credentials;

(4) be entered within 72 hours of service and contain a record and explanation of any delays in entry;

(5) clearly reflect clinical decision-making and support medical necessity;

(6) be securely stored in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191;

(7) be stored in accordance with state and federal document retention laws;

(8) be available for review or audit;

(9) include a record of caregiver involvement where applicable; and

(10) include a record of supervision and oversight for staff providing services requiring supervision under EIDBI policy.

(c) Each EIDBI service occurrence must be documented in a progress note in a manner and with the information determined by the commissioner.

(d) All providers must maintain current personnel records for each employee in a manner determined by the commissioner that include:

(1) the employee's name, contact information, and hire date;

(2) the employee's completed employment application and acknowledgment of duties;

(3) the job description for the employee's job with the effective date;

(4) verification of the employee's qualifications, including but not limited to education, licenses, certifications, enrollment attestation, degrees, transcripts, and experience;

(5) a background study pursuant to chapter 245C with a notice from the commissioner that the subject of the study is:

(i) not disqualified under section 245C.14; or

(ii) disqualified but the subject of the study has received a set-aside of the disqualification under section 245C.22;

(6) orientation and required training the employee attended, including but not limited to training on mandated reporting, cultural responsiveness, and EIDBI competencies;

(7) the dates of the employee's first supervised and unsupervised client contact following employment;

(8) documentation of supervision received by the employee, including but not limited to the supervisor's name and credentials, dates of supervision, supervision content, and the employee's signature indicating the accuracy of the documented supervision;

(9) the employee's CPR and emergency response training, if required; and

(10) the employee's annual performance evaluations.

(e) If an incident occurs or the person is injured while receiving services, the provider must document what occurred and how staff responded to the incident.

Sec. 27. Minnesota Statutes 2024, section 256B.4905, subdivision 2a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 10a, is amended to read:

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

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. The commissioner may review report submissions for inaccurate, inconclusive, incomplete, or otherwise deficient data and may remove the report from submitted status for further verification. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission

date. Withheld payments shall be made once data is received and reviewed for compliance by the commissioner.

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

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

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

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

Sec. 29. Minnesota Statutes 2024, section 256B.493, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services has the authority to manage statewide licensed corporate foster care or community residential settings capacity, including the reduction and realignment of licensed capacity of a current foster care or community residential setting to accomplish the consolidation or closure of settings. The commissioner shall implement a program for planned closure of licensed corporate adult foster care or community residential settings, necessary as a preferred method to~~: (1)~~ respond to the informed decisions of those individuals who want to move out of these settings into other types of community settings~~; and (2) achieve necessary budgetary savings required in section 245A.03, subdivision 7, paragraphs (c) and (d)~~.

Sec. 30. Minnesota Statutes 2024, section 256B.851, subdivision 8, is amended to read:

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

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) staff vacancy rates; and

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

(b) At least once in any three-year period, a provider must submit the required cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner must provide each provider a 90-day notice prior to its submission due date. The commissioner may review report submissions for inaccurate, inconclusive, incomplete, or otherwise deficient data and may remove the report from submitted status for further verification. If a provider fails to submit required cost data, the commissioner must provide notice to a provider that has not provided required cost data 30 days after the required submission date and a second notice to a provider that has not provided required cost data 60 days after the required submission date. The commissioner must temporarily suspend payments to a provider if the commissioner has not received required cost data 90 days after the required submission date. The commissioner must make withheld payments when the required cost data is received and reviewed for compliance by the commissioner.

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

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

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

Sec. 31. Minnesota Statutes 2024, section 256L.03, subdivision 1, is amended to read:

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

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

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

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

Sec. 32. Minnesota Statutes 2024, section 256R.481, is amended to read:

256R.481 RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.

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

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

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

(d) The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for ~~case mix classification PA1~~ the lowest case mix classification in effect of the nonprofit facilities located in an adjacent city in another state and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment rate for ~~case mix classification PA1~~ the lowest case mix classification in effect as determined under section 256R.22, subdivision 4.

EFFECTIVE DATE. This section is effective January 1, 2027, and applies to rate years beginning on or after January 1, 2027.

Sec. 33. Minnesota Statutes 2024, section 256S.205, subdivision 1, is amended to read:

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

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

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

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

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

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

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

Sec. 34. Minnesota Statutes 2025 Supplement, section 256S.205, subdivision 2, is amended to read:

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

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

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

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

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

Sec. 35. Minnesota Statutes 2024, section 256S.21, subdivision 3, is amended to read:

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

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

(b) At least once in any five-year period, a provider must submit the required cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner ~~shall~~ must provide each provider a 90-day notice prior to the provider's submission due date. The commissioner may review report submissions for inaccurate, inconclusive, incomplete, or otherwise deficient data and may remove the report from submitted status for further verification. If by 30 days after the required submission date a provider fails to submit required reporting data, the commissioner ~~shall~~ must provide notice to the provider~~, and~~. If by 60 days after the required submission date a provider has not provided the required data, the commissioner ~~shall~~ must provide a second notice. The commissioner ~~shall~~ must temporarily suspend payments to ~~the~~ a provider if the commissioner has not received the required cost data ~~is not received~~ 90 days after the required submission date or 90 days after the commissioner requests updated data. The commissioner must make withheld payments ~~must be made once data is received~~ when the required cost data is received and reviewed for compliance by the commissioner.

(c) The commissioner shall coordinate the cost reporting activities required under this section with the cost reporting activities directed under section 256B.4914, subdivision 10a.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders, may submit recommendations on rate methodologies in this chapter, including ways to monitor and enforce the spending requirements directed in section ~~256S.2101, subdivision 3,~~ 256S.211, subdivision 4, through the reports directed by subdivision 2.

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

Sec. 36. Laws 2023, chapter 61, article 1, section 67, subdivision 3, as amended by Laws 2024, chapter 125, article 8, section 10, is amended to read:

Subd. 3. **Evaluation and report.** (a) The Metropolitan Center for Independent Living must contract with a third party to evaluate the pilot project's impact on health care costs, retention of personal care assistants, and patients' and providers' satisfaction of care. The evaluation must include the number of participants, the hours of care provided by participants, and the retention of participants from semester to semester.

(b) By January 15, ~~2026~~ 2028, the Metropolitan Center for Independent Living must report the findings under paragraph (a) to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy.

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

Sec. 37. Laws 2023, chapter 61, article 9, section 2, subdivision 5, as amended by Laws 2024, chapter 125, article 8, section 12, is amended to read:

Subd. 5. **Central Office; Aging and Disability Services**	40,115,000	11,995,000

(a) **Employment Supports Alignment Study.** $50,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are to conduct an interagency employment supports alignment study. The base for this appropriation is $150,000 in fiscal year 2026 and $100,000 in fiscal year 2027.

(b) **Case Management Training Curriculum.** $377,000 in fiscal year 2024 and $377,000 in fiscal year 2025 are to develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for individuals who use home and community-based disability services and live in own-home settings. This is a onetime appropriation.

(c) **Office of Ombudsperson for Long-Term Care.** $875,000 in fiscal year 2024 and $875,000 in fiscal year 2025 are for additional staff and associated direct costs in the Office of Ombudsperson for Long-Term Care.

(d) **Direct Care Services Corps Pilot Project.** $500,000 in fiscal year 2024 is from the general fund for a grant to the Metropolitan Center for Independent Living for the direct care services corps pilot project. Up to $25,000 may be used by the Metropolitan Center for Independent Living for administrative costs. This is a onetime appropriation and is available until June 30, ~~2026~~ 2027.

(e) **Research on Access to Long-Term Care Services and Financing.** Any unexpended amount of the fiscal year 2023 appropriation referenced in Laws 2021, First Special Session chapter 7, article 17, section 16, estimated to be $300,000, is canceled. The amount canceled is appropriated in fiscal year 2024 for the same purpose.

(f) **Native American Elder Coordinator.** $441,000 in fiscal year 2024 and $441,000 in fiscal year 2025 are for the Native American elder coordinator position under Minnesota Statutes, section 256.975, subdivision 6.

(g) **Grant Administration Carryforward.**

(1) Of this amount, $8,154,000 in fiscal year 2024 is available until June 30, 2027.

(2) Of this amount, $1,071,000 in fiscal year 2025 is available until June 30, 2027.

(3) Of this amount, $19,000,000 in fiscal year 2024 is available until June 30, 2029.

(h) **Base Level Adjustment.** The general fund base is increased by $8,189,000 in fiscal year 2026 and increased by $8,093,000 in fiscal year 2027.

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

Sec. 38. Laws 2024, chapter 125, article 1, section 47, is amended to read:

Sec. 47. **DIRECTION TO COMMISSIONER; PEDIATRIC HOSPITAL-TO-HOME TRANSITION PILOT PROGRAM.**

(a) The commissioner of human services must award a single competitive grant to a home care nursing provider to develop and implement, in coordination with the commissioner of health, Fairview Masonic Children's Hospital, Gillette Children's Specialty Healthcare, and Children's Minnesota of St. Paul and Minneapolis, a pilot program to expedite and facilitate pediatric hospital-to-home discharges for patients receiving services in this state under medical assistance, including under the community alternative care waiver, community access for disability inclusion waiver, and developmental disabilities waiver.

(b) Grant money awarded under this section must be used only to support the administrative, training, and auxiliary services necessary to reduce:

(1) delayed discharge days due to unavailability of home care nursing staffing to accommodate complex pediatric patients;

(2) avoidable rehospitalization days for pediatric patients;

(3) unnecessary emergency department utilization by pediatric patients following discharge;

(4) long-term nursing needs for pediatric patients; and

(5) the number of school days missed by pediatric patients.

(c) Grant money must not be used to supplant payment rates for services covered under Minnesota Statutes, chapter 256B.

(d) No later than December 15, ~~2026~~ 2027, the commissioner must prepare a report summarizing the impact of the pilot program that includes but is not limited to: (1) the number of delayed discharge days eliminated; (2) the number of rehospitalization days eliminated; (3) the number of unnecessary emergency department admissions eliminated;

(4) the number of missed school days eliminated; and (5) an estimate of the return on investment of the pilot program.

(e) The commissioner must submit the report under paragraph (d) to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy.

Sec. 39. Laws 2024, chapter 125, article 8, section 2, subdivision 4, is amended to read:

Subd. 4. **Central Office; Aging and Disability Services**	(2,664,000)	4,164,000

(a) **Tribal Vulnerable Adult and Developmental Disabilities Targeted Case Management Medical Assistance Benefit.** $200,000 in fiscal year 2025 is for a contract to develop a Tribal vulnerable adult and developmental disabilities targeted case management medical assistance benefit under Minnesota Statutes, section 256B.0924. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(b) **Disability Services Person-Centered Engagement and Navigation Study.** $600,000 in fiscal year 2025 is for the disability services person-centered engagement and navigation study. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2026.

(c) **Pediatric Hospital-to-Home Transition Pilot Program Administration.** $300,000 in fiscal year 2025 is for a contract related to the pediatric hospital-to-home transition pilot program. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section

16A.28, subdivision 3, this appropriation is available until June 30, ~~2027~~ 2028.

(d) **Reimbursement for Community-First Services and Supports Workers Report.** $250,000 in fiscal year 2025 is for a contract related to the reimbursement for community-first services and supports workers report. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2026.

(e) **Carryforward Authority.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, $758,000 in fiscal year 2025 is available until June 30, 2026, and $2,687,000 in fiscal year 2025 is available until June 30, 2027.

(f) **Base Level Adjustment.** The general fund base is increased by $340,000 in fiscal year 2026 and increased by $340,000 in fiscal year 2027.

Sec. 40. Laws 2024, chapter 125, article 8, section 2, subdivision 14, as amended by Laws 2025, First Special Session chapter 9, article 12, section 29, is amended to read:

Subd. 14. **Grant Programs; Disabilities Grants**	1,650,000	9,574,000

(a) **Capital Improvement for Accessibility.** $400,000 in fiscal year 2025 is for a payment to Anoka County to make capital improvements to existing space in the Anoka County Human Services building in the city of Blaine, including making bathrooms fully compliant with the Americans with Disabilities Act with adult changing tables and ensuring barrier-free access for the purposes of improving and expanding the services an

existing building tenant can provide to adults with developmental disabilities. This is a onetime appropriation.

(b) **Dakota County Disability Services Workforce Shortage Pilot Project.** $500,000 in fiscal year 2025 is for a grant to Dakota County for innovative solutions to the disability services workforce shortage. Up to $250,000 of this amount must be used to develop and test an online application for matching requests for services from people with disabilities to available staff, and up to $250,000 of this amount must be used to develop a communities-for-all program that engages businesses, community organizations, neighbors, and informal support systems to promote community inclusion of people with disabilities. By October 1, 2026, the commissioner shall report the outcomes and recommendations of these pilot projects to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(c) **Pediatric Hospital-to-Home Transition Pilot Program.** $1,040,000 in fiscal year 2025 is for the pediatric hospital-to-home pilot program. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, ~~2027~~ 2028.

(d) **Artists With Disabilities Support.** $690,000 in fiscal year 2025 is for a payment to a nonprofit organization licensed under Minnesota Statutes, chapter 245D, located on Minnehaha Avenue West in Saint Paul, and that supports artists with disabilities in creating visual and performing art that challenges society's views of persons with disabilities. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(e) **Emergency Relief Grants for Rural EIDBI Providers.** $600,000 in fiscal year 2025 is for emergency relief grants for EIDBI providers. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(f) **Self-Advocacy Grants for Persons with Intellectual and Developmental Disabilities.** $250,000 in fiscal year 2025 is for self-advocacy grants under Minnesota Statutes, section 256.477, subdivision 1, paragraph (a), clauses (5) to (7), and for administrative costs. This is a onetime appropriation and is available until June 30, 2027.

(g) **Electronic Visit Verification Implementation Grants.** $864,000 in fiscal year 2025 is for electronic visit verification implementation grants. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(h) **Aging and Disability Services for Immigrant and Refugee Communities.** $250,000 in fiscal year 2025 is for a payment to SEWA-AIFW to address aging, disability, and mental health needs for immigrant and refugee communities. This is a onetime appropriation and is available until June 30, 2027.

(i) **License Transition Support for Small Disability Waiver Providers.** $3,150,000 in fiscal year 2025 is for license transition payments to small disability waiver providers. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027.

(j) **Own home services provider capacity-building grants.** $1,519,000 in fiscal year 2025 is for the own home services provider capacity-building grant program. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(k) **Continuation of Centers for Independent Living HCBS Access Grants.** $311,000 in fiscal year 2024 is for continued funding of grants awarded under Laws 2021, First Special Session chapter 7, article 17, section 19, as amended by Laws 2022, chapter 98, article 15, section 15. This is a onetime appropriation and is available until June 30, 2025.

(l) **Base Level Adjustment.** The general fund base is increased by $811,000 in fiscal year

2026 and increased by $811,000 in fiscal year 2027.

Sec. 41. **REVISOR INSTRUCTION.**

In each section of Minnesota Statutes referred to in column A, the revisor of statutes shall delete the reference in column B and insert the reference in column C.

A	B	C
Minnesota Statutes, section 245A.03, subdivision 9	subdivision 7	section 245A.03, subdivision 7b
Minnesota Statutes, section 245A.11, subdivision 2a, paragraph (e)	section 245A.03, subdivision 7	section 245A.03, subdivisions 7b to 7d
Minnesota Statutes, section 256B.092, subdivision 11, paragraph (c)	section 245A.03, subdivision 7, paragraph (f)	section 245A.03, subdivision 7d, paragraph (c)
Minnesota Statutes, section 256B.092, subdivision 11a, paragraph (b)	section 245A.03, subdivision 7	section 245A.03, subdivisions 7b to 7d
Minnesota Statutes, section 256B.092, subdivision 11a, paragraph (c)	section 245A.03, subdivision 7, paragraph (a)	section 245A.03, subdivision 7c
Minnesota Statutes, section 256B.092, subdivision 13, paragraph (c)	section 245A.03, subdivision 7, paragraph (a)	section 245A.03, subdivision 7c
Minnesota Statutes, section 256B.49, subdivision 24, paragraph (c)	section 245A.03, subdivision 7, paragraph (a)	section 245A.03, subdivision 7c
Minnesota Statutes, section 256B.49, subdivision 29, paragraph (b)	section 245A.03, subdivision 7	section 245A.03, subdivisions 7b to 7d
Minnesota Statutes, section 256B.49, subdivision 29, paragraph (c)	section 245A.03, subdivision 7, paragraph (a)	section 245A.03, subdivision 7b

Sec. 42. **REPEALER.**

(a) Minnesota Statutes 2024, sections 245A.03, subdivision 7; 256B.051, subdivisions 1, 4, and 7; and 256B.5012, subdivisions 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, and 16, are repealed.

(b) Minnesota Statutes 2025 Supplement, section 256B.051, subdivisions 2, 3, 5, 6, 6a, 6b, 8, 9, and 10, are repealed.

(c) Laws 2025, First Special Session chapter 3, article 18, section 3, is repealed.

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

ARTICLE 5
BEHAVIORAL HEALTH

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

Subdivision 1. **Availability of emergency services.** (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. Clients must not be charged for services provided and emergency service providers must not delay or deny the timely provision of emergency services to a client due to payor source for the services provided. Emergency service providers must meet the qualifications under section 256B.0624, subdivision 4. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of each client;

(2) minimize further deterioration of each client;

(3) help each client to obtain ongoing care and treatment;

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Sec. 2. Minnesota Statutes 2025 Supplement, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 142D.15 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with mental illness as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with mental illness or serious mental illness who are at risk of residential treatment or hospitalization; who are already in residential treatment or therapeutic foster care or in family foster settings as defined in chapter 142B and at risk of change in foster care or placement in a residential facility or other higher level of care; who have utilized crisis services or emergency room services; or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation under section 245.4908;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners;

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants; and

(19) evidence-based interventions for youth and young adults at risk of developing or experiencing an early episode of bipolar disorder.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

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

Subdivision 1. **Establishment.** The commissioner of human services must establish an early childhood mental health consultation grant program to support the delivery of specialized mental health care consultation to child care, social services, educational, and health programs that serve children five years of age or younger.

Subd. 2. **Eligible applicants.** An applicant is eligible for an early childhood mental health consultation grant under this section if the applicant is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

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

(5) an agency with expertise in infant and early childhood mental health that has the competency to provide early childhood mental health consultation and training.

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

(1) supporting early identification of social, emotional, and behavioral concerns for children five years of age or younger through observation, screening support, and guidance to early childhood professionals;

(2) developing and delivering training to early childhood professionals that includes evidence-based or evidence-informed clinical practices related to infant and early childhood mental health, and train-the-trainer models to build capacity for grantees to train the grantee's staff; and

(3) providing direct or reflective consultation to early childhood professionals.

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

(b) Grantees must collect and report the data required under paragraph (c) quarterly to the commissioner in a form and manner specified by the commissioner, for the purpose of evaluating the effectiveness of the grant program.

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

(1) the number of sites, programs, and early childhood professionals served by the grantee;

(2) demographics of participants served by the grantee; and

(3) data to demonstrate outcomes related to improving early childhood professionals' ability to support the mental, social, and emotional development of young children.

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

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

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

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

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

(3) be free from maltreatment;

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

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

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

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

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

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

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

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

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

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

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

(15) engage in chosen activities; and

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

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

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

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

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

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

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

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

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

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

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

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

(c) Except as provided under subdivision 4, restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's support plan or support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person

and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

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

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

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

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

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

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

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

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

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

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

(2) receive reasonable and prudent parenting.

(c) Restriction of the rights under subdivision 3, paragraph (a), clauses (13) to (16), or (b), clauses (1) to (4), for a person under 18 years of age is allowed only if determined

necessary to ensure the health, safety, and well-being of the person or pursuant to reasonable and prudent parenting standards.

Sec. 6. Minnesota Statutes 2024, section 245F.02, subdivision 17, is amended to read:

Subd. 17. **Peer recovery support services.** "Peer recovery support services" means services provided according to section ~~245F.08, subdivision 3~~ 254B.052.

Sec. 7. Minnesota Statutes 2025 Supplement, section 245F.08, subdivision 3, is amended to read:

Subd. 3. **Peer recovery support services.** Peer recovery support services must meet the requirements in section ~~245G.07, subdivision 2a, paragraph (b), clause (2)~~ 254B.052, and must be provided by a person who is qualified according to the requirements in section ~~245F.15, subdivision 7~~ 245I.04, subdivisions 18 and 19.

Sec. 8. Minnesota Statutes 2024, section 245F.15, subdivision 7, is amended to read:

Subd. 7. **Recovery peer qualifications.** Recovery peers must:

(1) meet the qualifications in section 245I.04, subdivision 18; and

(2) provide services according to the scope of practice established in section 245I.04, subdivision 19~~, under the supervision of an alcohol and drug counselor~~.

Sec. 9. Minnesota Statutes 2024, section 245G.04, is amended by adding a subdivision to read:

Subd. 4. **Tobacco educational material.** A license holder must provide tobacco and nicotine educational material to a client on the day of service initiation. The license holder must use educational material approved by the commissioner that contains information on:

(1) risks associated with use of tobacco or nicotine products;

(2) types of tobacco or nicotine products, including differentiating between commercial versus traditional or sacred tobacco;

(3) treatment options, including the use of medication for tobacco use disorder; and

(4) benefits of receiving treatment for tobacco or nicotine use while attending substance use disorder treatment for another primary substance.

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

Sec. 10. Minnesota Statutes 2024, section 245G.06, subdivision 4, is amended to read:

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a service discharge summary for each client. The service discharge summary must be completed within five days of the client's service termination, excluding weekends and holidays. A copy of the client's service discharge summary must be provided to the client upon the client's request.

(b) The service discharge summary must be recorded in the six dimensions listed in section 254B.04, subdivision 4, and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk rating and description for each of the ASAM six dimensions;

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the requirements in section 245G.14, subdivision 3, clause (3);

(5) the client's living arrangements at service termination;

(6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and

(7) service termination diagnosis.

Sec. 11. Minnesota Statutes 2025 Supplement, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** (a) Client records must contain the following:

(1) documentation that the client was given:

(i) information on client rights and responsibilities and grievance procedures on the day of service initiation;

(ii) information on tuberculosis and HIV within 72 hours of service initiation;

(iii) an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4), within 24 hours of admission or, for clients who would benefit from a later orientation, 72 hours; and

(iv) opioid educational material according to section 245G.04, subdivision 3, and tobacco educational material according to section 245G.04, subdivision 4, on the day of service initiation;

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(5) an individual treatment plan according to section 245G.06, subdivisions 1 and 1a;

(6) documentation of treatment services, significant events, appointments, concerns, and treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, 3, and 3a; and

(7) a summary at the time of service termination according to section 245G.06, subdivision 4.

(b) For a client that transfers to another of the license holder's licensed treatment locations, the license holder is not required to complete new documents or orientation for the client, except that the client must receive an orientation to the new location's grievance procedure, program abuse prevention plan, and maltreatment of minor and vulnerable adults reporting procedures.

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

Sec. 12. Minnesota Statutes 2025 Supplement, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment coordination if the individual meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has completed 15 hours of education or training on substance use disorder, co-occurring conditions, and care coordination for individuals with substance use disorder or co-occurring conditions that is consistent with national evidence-based standards;

(4) meets one of the following criteria:

~~(i) has a bachelor's degree in one of the behavioral sciences or related fields;~~

~~(ii)~~ (i) has a high school diploma or equivalent; or

~~(iii)~~ (ii) is a mental health practitioner who meets the qualifications under section 245I.04, subdivision 4; and

(5) either has at least 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions or receives treatment supervision at least once per week until obtaining 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions.

(b) A treatment coordinator must receive the following levels of supervision from an alcohol and drug counselor or a mental health professional whose scope of practice includes substance use disorder treatment and assessments:

(1) for a treatment coordinator that has not obtained 1,000 hours of supervised experience under paragraph (a), clause (5), at least one hour of supervision per week; or

(2) for a treatment coordinator that has obtained at least 1,000 hours of supervised experience under paragraph (a), clause (5), at least one hour of supervision per month.

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

Sec. 13. Minnesota Statutes 2024, section 245G.11, subdivision 8, is amended to read:

Subd. 8. **Recovery peer qualifications.** A recovery peer must:

(1) meet the qualifications in section 245I.04, subdivision 18; and

(2) provide services according to the scope of practice established in section 245I.04, subdivision 19~~, under the supervision of an alcohol and drug counselor~~.

Sec. 14. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended to read:

Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment supervision of a mental health professional, a mental health behavioral aide may practice psychosocial skills with a child client according to the child's treatment plan ~~and individual~~

~~behavior plan~~ that a mental health professional, clinical trainee, or behavioral health practitioner has previously taught to the child.

Sec. 15. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, including withdrawal symptoms, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment, including but not limited to treatment for tobacco or nicotine use;

(10) cultural influences on the client; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, including but not limited to tobacco and nicotine products; frequency and duration~~,~~; route of administration~~,~~; periods of abstinence~~,~~; and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder, including but not limited to tobacco use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

(g) Information from other providers and prior assessments may be used to complete the diagnostic assessment if the source of the information is documented in the diagnostic assessment.

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

Sec. 16. Minnesota Statutes 2025 Supplement, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) An eligible vendor of comprehensive assessments under section 254B.0501 may determine the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the behavioral health fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

~~(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.~~

~~(c)~~ (b) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.0505. The initial set of services approved for a recipient whose screen result

is positive may include any combination of up to four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services. A comprehensive assessment pursuant to section 245G.05 is not required to receive the initial set of services allowed under this subdivision. A positive screen result establishes eligibility for the initial set of services allowed under this subdivision.

~~(d)~~ (c) An individual may choose to obtain a comprehensive assessment as provided in section 245G.05. Individuals obtaining a comprehensive assessment may access any enrolled provider that is licensed to provide the level of service authorized pursuant to section 254A.19, subdivision 3. If the individual is enrolled in a prepaid health plan, the individual must comply with any provider network requirements or limitations.

Sec. 17. Minnesota Statutes 2025 Supplement, section 254B.04, subdivision 1a, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the commissioner to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.0505, subdivision 1, clause (9).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 142G;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0140;

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

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by the commissioner under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.0501, subdivision 3.

(i) Notwithstanding any laws to the contrary, persons enrolled in MinnesotaCare or medical assistance are eligible for room and board services when provided through intensive

residential treatment services and residential crisis services under section 256B.0632 and chapter 245I.

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

Sec. 18. Minnesota Statutes 2025 Supplement, section 254B.0501, subdivision 6, is amended to read:

Subd. 6. **Recovery community organizations.** (a) A recovery community organization that meets the requirements of clauses (1) to (15), complies with the training requirements in section 254B.052, subdivision 4, and meets certification requirements of the Minnesota Alliance of Recovery Community Organizations or another Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. If the commissioner does not identify another statewide recovery organization, or the Minnesota Alliance of Recovery Community Organizations or the statewide recovery organization identified by the commissioner is not reasonably positioned to certify vendors, the commissioner must determine the eligibility of a vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification on the status of the application within 45 days of receipt. If the approved statewide recovery organization denies an application, it must provide a written explanation for the denial to the recovery community organization. Eligible vendors under this paragraph must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be free from conflicting self-interests, and be autonomous in decision-making, program development, peer recovery support services provided, and advocacy efforts for the purpose of supporting the recovery community organization's mission;

(2) be led and governed by individuals in the recovery community, with more than 50 percent of the board of directors or advisory board members self-identifying as people in personal recovery from substance use disorders;

(3) have a mission statement and conduct corresponding activities indicating that the organization's primary purpose is to support recovery from substance use disorder;

(4) demonstrate ongoing community engagement with the identified primary region and population served by the organization, including individuals in recovery and their families, friends, and recovery allies;

(5) be accountable to the recovery community through documented priority-setting and participatory decision-making processes that promote the engagement of, and consultation with, people in recovery and their families, friends, and recovery allies;

(6) provide nonclinical peer recovery support services, including but not limited to recovery support groups, recovery coaching, telephone recovery support, skill-building, and harm-reduction activities, and provide recovery public education and advocacy;

(7) have written policies that allow for and support opportunities for all paths toward recovery and refrain from excluding anyone based on their chosen recovery path, which may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based paths;

(8) maintain organizational practices to meet the needs of Black, Indigenous, and people of color communities, LGBTQ+ communities, and other underrepresented or marginalized communities. Organizational practices may include board and staff training, service offerings, advocacy efforts, and culturally informed outreach and services;

(9) use recovery-friendly language in all media and written materials that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma;

(10) establish and maintain a publicly available recovery community organization code of ethics and grievance policy and procedures;

(11) not classify or treat any recovery peer hired on or after July 1, 2024, as an independent contractor;

(12) not classify or treat any recovery peer as an independent contractor on or after January 1, 2025;

(13) provide an orientation for recovery peers that includes an overview of the consumer advocacy services provided by the Ombudsman for Mental Health and Developmental Disabilities and other relevant advocacy services;

(14) provide notice to peer recovery support services participants that includes the following statement: "If you have a complaint about the provider or the person providing your peer recovery support services, you may contact the Minnesota Alliance of Recovery

Community Organizations. You may also contact the Office of Ombudsman for Mental Health and Developmental Disabilities." The statement must also include:

(i) the telephone number, website address, email address, and mailing address of the Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(ii) the recovery community organization's name, address, email, telephone number, and name or title of the person at the recovery community organization to whom problems or complaints may be directed; and

(iii) a statement that the recovery community organization will not retaliate against a peer recovery support services participant because of a complaint; and

(15) comply with the requirements of section 245A.04, subdivision 15a.

(b) A recovery community organization approved by the commissioner before June 30, 2023, must have begun the application process as required by an approved certifying or accrediting entity and have begun the process to meet the requirements under paragraph (a) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(c) A recovery community organization that is aggrieved by a certification determination and believes it meets the requirements under paragraph (a) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (a), the recovery community organization is an eligible vendor of peer recovery support services for up to two years from the date of the determination. After two years, the recovery community organization must apply for certification under paragraph (a) to continue to be an eligible vendor of peer recovery support services.

(d) All recovery community organizations must be certified by an entity listed in paragraph (a) by June 30, ~~2027~~ 2026.

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

Sec. 19. Minnesota Statutes 2025 Supplement, section 254B.0505, subdivision 8, is amended to read:

Subd. 8. **~~Peer recovery support services~~ Utilization review requirements.** Eligible vendors of ~~peer recovery support~~ services in subdivision 1, clauses (1) to (10), must~~:~~

~~(1)~~ submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity ~~of peer recovery support services for entities billing for peer recovery support services individually and not receiving a daily rate; and~~.

~~(2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.~~

Sec. 20. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding a subdivision to read:

Subd. 9. **Withdrawal management services.** For withdrawal management services provided by an eligible vendor that is licensed under chapter 245F as a clinically managed withdrawal management program or as a medically monitored withdrawal management program, utilization review, as defined in section 62M.02, may occur but may not be initiated until five calendar days after the date of service initiation.

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

Sec. 21. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding a subdivision to read:

Subd. 10. **Monetary recovery.** Reimbursement for services authorized under this chapter that are not provided in accordance with this chapter are subject to monetary recovery under section 256B.064 as money improperly paid.

Sec. 22. Minnesota Statutes 2024, section 254B.052, subdivision 1, is amended to read:

Subdivision 1. **Peer recovery support services; service requirements.** (a) Peer recovery support services are face-to-face interactions between a recovery peer and a client, on a one-on-one basis, in which specific goals identified in an individual recovery plan, treatment plan, or stabilization plan are discussed and addressed. Peer recovery support services are provided to promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports and to support maintenance of a client's recovery.

(b) Peer recovery support services must be provided according to (1) an individual recovery plan if provided by a recovery community organization or county, (2) a treatment plan if provided in either a substance use disorder treatment program under chapter 245G~~,~~ or a Tribally licensed substance use disorder treatment program, or (3) a stabilization plan if provided by a withdrawal management program under chapter 245F.

(c) A client receiving peer recovery support services must participate in the services voluntarily. Any program that incorporates peer recovery support services must provide written notice to the client that peer recovery support services will be provided.

(d) Peer recovery support services may not be provided to a client residing with or employed by a recovery peer from whom ~~they receive~~ the client receives services.

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

Sec. 23. Minnesota Statutes 2024, section 254B.052, is amended by adding a subdivision to read:

Subd. 7. **Billing limits.** Eligible vendors of peer recovery support services must limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.

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

Sec. 24. Minnesota Statutes 2024, section 256B.0623, subdivision 6, is amended to read:

Subd. 6. **Required supervision.** (a) A treatment supervisor providing treatment supervision required by section 245I.06 must:

(1) meet with staff receiving treatment supervision at least monthly to discuss treatment topics of interest and treatment plans of recipients; and

(2) meet at least monthly with the directing clinical trainee or mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing clinical trainee or mental health practitioner.

(b) A treatment supervisor providing treatment supervision required by section 245I.06 must complete an attestation form in a manner provided by the commissioner. This form must be completed at least annually, and updated upon any change in the number of organizations the treatment supervisor is affiliated with under this section or section 256B.0943. The attestation must include:

(1) the total number of staff and full-time equivalent staff the treatment supervisor supervises, across all programs under this section and section 256B.0943, which must not exceed 20 full-time equivalent staff; and

(2) the name and national provider identifier of each organization for which the treatment supervisor provides supervision under this section or section 256B.0943, which must not exceed ten organizations.

(c) The commissioner may grant an exception to the limitations in paragraph (b), clauses (1) and (2). The commissioner must develop criteria and a standardized process for evaluating exception requests and may rescind approval of an exception if the treatment supervisor fails to comply with applicable program standards.

~~(b)~~ (d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The treatment director must:

(1) ensure the direct observation of mental health rehabilitation workers required by section 245I.06, subdivision 3, is provided;

(2) ensure immediate availability by phone or in person for consultation by a mental health professional, certified rehabilitation specialist, clinical trainee, or a mental health practitioner to the mental health rehabilitation worker during service provision;

(3) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(4) ensure that clinical trainees, mental health practitioners, and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(5) oversee the record of the results of direct observation, progress note evaluation, and corrective actions taken to modify the work of the clinical trainees, mental health practitioners, and mental health rehabilitation workers.

~~(c)~~ (e) A clinical trainee or mental health practitioner who is providing treatment direction for a provider entity must receive treatment supervision at least monthly to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

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

Sec. 25. Minnesota Statutes 2024, section 256B.0624, subdivision 6b, is amended to read:

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 26. Minnesota Statutes 2024, section 256B.0624, subdivision 7, is amended to read:

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

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

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

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment,

help with referrals, updating of the crisis treatment plan, skills training, and collaboration with other service providers in the community; ~~and~~

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

(5) for a recipient who is 18 years of age or older, the case manager or crisis team must offer to work with the recipient to develop a health care directive, as defined in section 145C.01, subdivision 5a, or a declaration of preferences under section 253B.03, subdivision 6d, if the recipient's mental health crisis is stabilized and the recipient does not have a directive or declaration.

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

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 27. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, is amended to read:

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

(b) The commissioner ~~shall~~ must reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner ~~shall~~ must include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph

(e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

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

(1) the CCBHC daily bundled rate ~~shall~~ must be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

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

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

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

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

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

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

(8) the CCBHC daily bundled rate for each CCBHC ~~shall~~ must be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update ~~shall~~ must occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

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

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

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

(1) a CCBHC ~~shall~~ must receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition

to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

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

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

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner ~~shall~~ must notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

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

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

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

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

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

Sec. 28. Minnesota Statutes 2024, section 256B.0625, subdivision 47, is amended to read:

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

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

Sec. 29. Minnesota Statutes 2024, section 256B.0759, subdivision 3, is amended to read:

Subd. 3. **Provider standards.** (a) ~~The commissioner must establish requirements for participating providers that are consistent with the federal requirements of the demonstration project.~~ The following programs that receive payment for substance use disorder treatment services under section 256B.0625 must enroll as a Minnesota Health Care Programs provider, meet the requirements established by the commissioner, and certify that the program meets the applicable American Society of Addiction Medicine (ASAM) levels of care according to section 254B.19:

(1) nonresidential substance use disorder treatment programs and residential treatment programs licensed under chapter 245G as licensed substance use disorder treatment facilities;

(2) withdrawal management programs licensed under chapter 245F; and

(3) out-of-state residential substance use disorder treatment programs.

Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

~~(b) A participating residential provider must obtain applicable licensure under chapter 245F or 245G or other applicable standards for the services provided and must:~~

~~(1) deliver services in accordance with standards published by the commissioner pursuant to paragraph (d);~~

~~(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards; and~~

~~(3) offer substance use disorder treatment services with medications for opioid use disorder on site or facilitate access to substance use disorder treatment services with medications for opioid use disorder off site.~~

~~(c) A participating outpatient provider must obtain applicable licensure under chapter 245G or other applicable standards for the services provided and must:~~

~~(1) deliver services in accordance with standards published by the commissioner pursuant to paragraph (d); and~~

~~(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards.~~

~~(d) If the provider standards under chapter 245G or other applicable standards conflict or are duplicative, the commissioner may grant variances to the standards if the variances do not conflict with federal requirements. The commissioner must publish service components, service standards, and staffing requirements for participating providers that are consistent with ASAM standards and federal requirements by October 1, 2020.~~

(b) Programs licensed by the commissioner as residential treatment programs according to section 245G.21 that (1) receive payment under this chapter, (2) are licensed as a hospital under sections 144.50 to 144.581, and (3) provide only ASAM level 3.7 medically monitored inpatient level of care are not required to certify the ASAM 3.7 level of care. If a program described in this paragraph provides any additional ASAM levels of care, the program must certify those levels of care according to section 254B.19. Programs meeting the criteria in this paragraph must submit evidence of providing the required level of care to the commissioner to be exempt from enrolling in the demonstration.

(c) Tribally licensed programs that otherwise meet the requirements of this subdivision may elect to participate in the demonstration project. The commissioner must consult with Tribal Nations to discuss participation in the substance use disorder demonstration project.

(d) Programs subject to this section must:

(1) deliver services in accordance with section 254B.19; and

(2) offer substance use disorder treatment services with medications for opioid use disorder on site or facilitate timely access to medications for opioid use disorder off site.

Sec. 30. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is amended to read:

Subd. 4. **Provider payment rates.** (a) ~~Payment rates for participating~~ Providers must ~~be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care. Providers that have enrolled in the demonstration project but have not met the provider standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under this subdivision until the date that the provider meets the provider standards in subdivision~~

~~3. Services provided from July 1, 2022, to the date that the provider meets the provider standards under subdivision 3 shall~~ be reimbursed at rates according to section 254B.0505, subdivision 1. ~~Rate increases paid under this subdivision to a provider for services provided between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider is taking meaningful steps to meet demonstration project requirements that are not otherwise required by law, and the provider provides documentation to the commissioner, upon request, of the steps being taken.~~

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

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

~~(d)~~ (b) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the ~~criteria described in paragraph (a) who~~ requirements of section 254B.19 that are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraph ~~(c)~~ (a). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

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

~~(f)~~ (d) For substance use disorder services with medications for opioid use disorder under section 254B.0505, subdivision 1, clause (7), provided on or after January 1, 2021, payment

rates must be increased by 20 percent over the rates in effect on December 31, 2020. Upon implementation of new rates according to section 254B.121, the 20 percent increase will no longer apply.

Sec. 31. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 1, is amended to read:

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

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness, as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for ~~three~~ two or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

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

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

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

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

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

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

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

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

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

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

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

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

(q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate

for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

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

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

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

Sec. 32. Minnesota Statutes 2024, section 256B.0943, subdivision 6, is amended to read:

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

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

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

(2) developing an individual treatment plan;

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

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

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

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

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

Sec. 33. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a team under the treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and

Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. ~~A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.~~

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of ~~three~~ two to eight clients; or

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

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

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

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

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

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

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the

child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

Sec. 34. Minnesota Statutes 2024, section 256B.0943, is amended by adding a subdivision to read:

Subd. 14. **Treatment supervision limits.** (a) A treatment supervisor providing treatment supervision required by section 245I.06 must complete an attestation form in a manner provided by the commissioner. This form must be completed at least annually, and updated upon any change in the number of organizations the treatment supervisor is affiliated with under this section or section 256B.0623. The attestation must include:

(1) the total number of staff and full-time equivalent staff the treatment supervisor supervises, across all programs under this section and section 256B.0623, which must not exceed 20 full-time equivalent staff; and

(2) the name and national provider identifier of each organization for which the treatment supervisor provides supervision under this section or section 256B.0623, which must not exceed ten organizations.

(b) The commissioner may grant an exception to the limitations in paragraph (a), clauses (1) and (2). The commissioner must develop criteria and a standardized process for evaluating exception requests and may rescind approval of an exception if the treatment supervisor fails to comply with applicable program standards.

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

Sec. 35. Minnesota Statutes 2024, section 256B.0946, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2025 Supplement, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities that are covered by a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph (r);

(3) crisis planning as defined in section 245.4871, subdivision 9a;

(4) medication management provided by a ~~physician, an advanced practice registered nurse with certification in psychiatric and mental health care, or a physician assistant~~ qualified provider;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0624;

(11) transition services;

(12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

(13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity: client access to crisis intervention services, as defined in section 256B.0624, and available 24 hours per day and seven days per week.

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

Sec. 37. Minnesota Statutes 2024, section 256B.0947, subdivision 5, is amended to read:

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

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

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

(1) Based on professional qualifications and client needs, clinically qualified core team members are assigned on a rotating basis as the client's lead worker to coordinate a client's

care. The core team must comprise at least four full-time equivalent direct care staff and must minimally include:

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

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

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

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

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

(i) additional mental health professionals;

(ii) a vocational specialist;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 38. Minnesota Statutes 2025 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention, crisis stabilization provided in a community setting, or crisis assessment as defined in section 256B.0624, subdivision 2.

Sec. 39. **DIRECTION TO COMMISSIONER; CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC REBASING.**

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

Sec. 40. **REPEALER.**

(a) Minnesota Statutes 2024, section 256B.0759, subdivisions 2 and 5, are repealed.

(b) Minnesota Statutes 2025 Supplement, section 254B.052, subdivision 6, is repealed.

ARTICLE 6
DEPARTMENT OF HUMAN SERVICES HOUSING AND SUPPORT SERVICES

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

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2024, section 256D.54, subdivision 1, is amended to read:

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

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

ARTICLE 7
MALTREATMENT OF VULNERABLE ADULTS

Section 1. Minnesota Statutes 2024, section 144.6512, subdivision 6, is amended to read:

Subd. 6. **Other laws.** Nothing in this section affects the rights and remedies available under section 626.557, subdivisions ~~10~~ 11b to 11j, 17, and 20.

Sec. 2. Minnesota Statutes 2024, section 144A.161, subdivision 8, is amended to read:

Subd. 8. **Responsibilities of county social services agency.** (a) The county social services agency shall participate in the meeting as outlined in subdivision 3, paragraph (b), to develop a relocation plan.

(b) The county social services agency shall designate a representative to the interdisciplinary team established by the licensee responsible for coordinating the relocation efforts.

(c) The county social services agency shall serve as a resource in the relocation process.

(d) Concurrent with the notice sent to residents from the licensee as provided in subdivision 5a, the county social services agency shall provide written notice to residents and responsible parties describing:

(1) the county's role in the relocation process and in the follow-up to relocations;

(2) the county social services agency contact information; and

(3) the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(e) The county social services agency designee shall meet with appropriate facility staff to coordinate any assistance in the relocation process. This coordination shall include participating in group meetings with residents, families, and responsible parties to explain the relocation process.

(f) Beginning from the initial notice given in subdivision 2, the county social services agency shall monitor compliance with all components of this section and the plan developed under subdivision 3, paragraph (b). If the licensee is not in compliance, the county social services agency shall notify the commissioner of the Department of Health and the commissioner of the Department of Human Services.

(g) Except as requested by the resident or responsible party and within the parameters of the Vulnerable Adults Act, the county social services agency, in coordination with the commissioner of health and the commissioner of human services, may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident. In situations where a resident relocation is halted, the county social services agency must notify the resident, family, responsible parties, Office of the Ombudsman for Long-Term Care and Office of the Ombudsman for Mental Health and Developmental Disabilities, and resident's managed care organization, of this action. The county social services agency shall pursue remedies to protect the resident during the relocation process, including, but not limited to, assisting the resident with filing an appeal of transfer or discharge, notification of all appropriate licensing boards and agencies, and other remedies available to the county under section 626.557, ~~subdivision 10~~ subdivisions 11b to 11j.

(h) A member of the county social services agency staff shall follow up with relocated residents within 30 days after the relocation. This requirement does not apply to changes in operation where the facility moved to a new location and residents chose to move to that new location. The requirement also does not apply to residents admitted after the notice in subdivision 5a is given and discharged prior to the actual change in facility operations or reduction. County social services agency staff shall interview the resident or responsible

party and review and discuss pertinent medical or social records with appropriate facility staff to:

(1) assess the adjustment of the resident to the new placement;

(2) recommend services or methods to meet any special needs of the resident; and

(3) identify residents at risk.

(i) The county social services agency shall conduct subsequent follow-up visits on site in cases where the adjustment of the resident to the new placement is in question.

(j) Within 60 days of the completion of the follow up under paragraphs (h) and (i), the county social services agency shall submit a written summary of the follow-up work to the Department of Health and the Department of Human Services in a manner approved by the commissioners.

(k) The county social services agency shall submit to the Department of Health and the Department of Human Services a report of any issues that may require further review or monitoring.

(l) The county social services agency shall be responsible for the safe and orderly relocation of residents in cases where an emergent need arises or when the licensee has abrogated its responsibilities under the plan.

Sec. 3. Minnesota Statutes 2024, section 144G.92, subdivision 5, is amended to read:

Subd. 5. **Other laws.** Nothing in this section affects the rights and remedies available under section 626.557, subdivisions ~~10~~ 11b to 11j, 17, and 20.

Sec. 4. Minnesota Statutes 2024, section 152.137, subdivision 6, is amended to read:

Subd. 6. **Reporting maltreatment of vulnerable adult.** (a) A peace officer shall make a report of suspected maltreatment of a vulnerable adult if the vulnerable adult is present in an area where any of the activities described in subdivision 2, paragraph (a), clauses (1) to (4), are taking place, and the peace officer has reason to believe the vulnerable adult inhaled, was exposed to, had contact with, or ingested methamphetamine, a chemical substance, or methamphetamine paraphernalia. The peace officer shall immediately report to the county common entry point as described in section 626.557, subdivision 9b.

(b) As required in section 626.557, subdivision 9b, law enforcement is the primary agency to conduct investigations of any incident when there is reason to believe a crime has been committed. Law enforcement shall initiate a response immediately. If the common

entry point notified a county agency for adult protective services, law enforcement shall cooperate with that county agency when both agencies are involved and shall exchange data to the extent authorized in section 626.557, subdivision 12b, paragraph (g). County adult protection shall initiate a response immediately.

(c) The county social services agency shall immediately respond as required in section 626.557, ~~subdivision 10~~ subdivisions 11b to 11j, upon receipt of a report from the common entry point staff.

Sec. 5. Minnesota Statutes 2025 Supplement, section 524.5-311, is amended to read:

524.5-311 EMERGENCY GUARDIAN.

(a) If the court finds that compliance with the procedures of this article will likely result in substantial harm to the respondent's health, safety, or welfare, and that no other person appears to have authority and willingness to act in the circumstances, the court, on petition by a person interested in the respondent's welfare, may appoint an emergency guardian whose authority may not exceed 60 days and who may exercise only the powers specified in the order. A county that is acting under section 626.557, ~~subdivision 10~~ subdivisions 11h and 11i, by petitioning for appointment of an emergency guardian on behalf of a vulnerable adult may be granted authority to act for a period not to exceed 90 days. An emergency guardian's appointment under this section may only be extended once for a period not to exceed 60 days if the court finds good cause for the continuation of the guardianship. Immediately upon receipt of the petition for an emergency guardianship, the court shall appoint a lawyer to represent the respondent in the proceeding. Except as otherwise provided in paragraph (b), reasonable notice of the time and place of a hearing on the petition must be given to the respondent; interested parties, if known; and any other persons as the court directs.

(b) An emergency guardian may be appointed without notice to the respondent and the respondent's lawyer only if the court finds from affidavit or other sworn testimony that the respondent will be substantially harmed before a hearing on the appointment can be held and the petitioner made good faith efforts to provide notice to the respondent or the respondent's lawyer. If the court appoints an emergency guardian without notice to the respondent, the respondent must be given notice of the appointment within 48 hours after the appointment. The court shall hold a hearing on the appropriateness of the appointment within five days after the appointment.

(c) Appointment of an emergency guardian, with or without notice, is not a determination of the respondent's incapacity.

(d) The court may remove an emergency guardian at any time. An emergency guardian shall make any report the court requires. In other respects, the provisions of this article concerning guardians apply to an emergency guardian.

(e) Any documents or information disclosing or pertaining to health or financial information shall be filed as confidential documents, consistent with the bill of particulars under section 524.5-121.

(f) The mere fact that the respondent is a patient in a hospital or a resident of a facility is not in and of itself sufficient evidence to support a risk of substantial harm to the respondent's health, safety, or welfare.

Sec. 6. Minnesota Statutes 2024, section 524.5-409, subdivision 2, is amended to read:

Subd. 2. **Emergency and temporary conservator.** (a) If the court finds that compliance with the procedures of this article will likely result in the immediate loss, waste, or dissipation of the individual's assets or income unless management is provided, or money is needed for the support, care, education, health, and welfare of the individual or of individuals who are entitled to the individual's support and that protection is necessary or desirable to obtain or provide money, and that no other person appears to have authority and willingness to act in the circumstances, the court, on petition by a person interested in the respondent's welfare, may appoint an emergency conservator whose authority may not exceed 60 days and who may exercise only the powers specified in the order. A county that is acting under section 626.557, ~~subdivision 10~~ subdivisions 11h and 11i, by petitioning for appointment of an emergency conservator on behalf of a vulnerable adult may be granted authority to act for a period not to exceed 90 days. An emergency conservator's appointment under this section may be extended once for a period not to exceed 60 days if the court finds good cause for the continuation of the conservatorship. Immediately upon receipt of the petition for an emergency conservatorship, the court shall appoint a lawyer to represent the respondent in the proceeding. Except as otherwise provided in paragraph (b), reasonable notice of the time and place of a hearing on the petition must be given to the respondent and any other persons as the court directs.

(b) An emergency conservator may be appointed without notice to the respondent and the respondent's lawyer only if the court finds from affidavit or other sworn testimony that the respondent will be substantially harmed before a hearing on the appointment can be held. If the court appoints an emergency conservator without notice to the respondent, the respondent must be given notice of the appointment within 48 hours after the appointment.

The court shall hold a hearing on the appropriateness of the appointment within five days after the appointment.

(c) Appointment of an emergency conservator, with or without notice, is not a determination of the respondent's incapacity.

(d) The court may remove an emergency conservator at any time. An emergency conservator shall make any report the court requires. In other respects, the provisions of this article concerning conservators apply to an emergency conservator.

(e) If the court finds that a conservator is not effectively performing the conservator's duties and that the security and preservation of the assets of the person subject to conservatorship requires immediate action, the court may appoint a temporary substitute conservator for the person subject to conservatorship for a specified period not exceeding six months. Except as otherwise ordered by the court, a temporary substitute conservator so appointed has the powers set forth in the previous order of appointment. The authority of any unlimited or limited conservator previously appointed by the court is suspended as long as a temporary substitute conservator has authority. If an appointment is made without previous notice to the person subject to conservatorship or the affected conservator within five days after the appointment, the court shall inform the person subject to conservatorship or conservator of the appointment.

(f) The court may remove a temporary substitute conservator at any time. A temporary substitute conservator shall make any report the court requires. In other respects, the provisions of this article concerning conservators apply to a temporary substitute conservator.

(g) Any documents or information disclosing or pertaining to health or financial information shall be filed as confidential documents, consistent with the bill of particulars under section 524.5-121.

Sec. 7. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

Subd. 1a. **Adult protective services.** The Department of Human Services is the state agency responsible for supervision of adult protective services administered by county social services agencies.

Sec. 8. Minnesota Statutes 2024, section 626.557, subdivision 9, is amended to read:

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

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

(1) the time and date of the report;

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

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

(i) reporter;

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

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

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

(5) the time, date, and location of the incident;

(6) the immediate safety risk to the vulnerable adult;

(7) a description of the suspected maltreatment;

(8) the impact of the suspected maltreatment on the vulnerable adult;

(9) whether a facility was involved and, if so, which agency licenses the facility;

(10) the actions taken to protect the vulnerable adult;

(11) the required notifications and referrals made by the common entry point; and

(12) whether the reporter wishes to receive notification of the disposition.

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

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

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

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

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

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

Subd. 9a. **Evaluation and referral of reports made to common entry point.** (a) The common entry point must screen the reports of alleged or suspected maltreatment for

immediate risk and make all necessary referrals ~~as follows~~ using the referral guidelines established by the commissioner and the following:

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

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

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

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

(3) safety, assessment, and services plans;

(4) protective service interventions;

(5) use of guardianship and other involuntary interventions;

(6) final determination for maltreatment; and

(7) case closure decisions.

Sec. 11. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

Subd. 11c. **County social services agency; referrals.** (a) When the common entry point refers a report to the county social services agency as the lead investigative agency or makes a referral to the county social services agency for emergency adult protective services, or when another lead investigative agency requests adult protective services from the county social services agency for an adult referred to that lead investigative agency by the common entry point, the county social services agency must use the data report system and standardized decision and assessment tools provided by the commissioner of human services. The information entered by the county social services agency into the data system and standardized tools must be accessible to the Department of Human Services for the department to meet federal requirements, evaluate consistent application of policy, review quality of services and outcomes for adults, and meet requirements for background studies and disqualification of individuals determined responsible for vulnerable adult maltreatment under chapter 245C.

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

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

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

(c) For reports referred by the common entry point for emergency adult protective services, the county social services agency must immediately screen the report to determine whether the adult should be accepted for emergency adult protective services. If the adult is accepted for emergency adult protective services, the county social services agency must immediately offer protective services to prevent further maltreatment and safeguard the

welfare of the vulnerable adult. Assessment of adults accepted by the county social services agency for emergency protective services must be conducted in person by the agency or a designee within 24 hours of the agency receiving the referral. When sexual or physical abuse is suspected, the county social services agency must immediately arrange for and make available to the vulnerable adult appropriate medical examination and services.

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

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

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

Sec. 12. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

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

(b) The county social services agency must conduct assessments concurrently with investigations when the county is the lead investigative agency.

(c) The county social services agency must conduct an assessment to initiate adult protective services:

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

(2) within 24 hours of making an initial disposition that the adult is in immediate need of protection; or

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

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

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

Sec. 13. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

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

(1) abuse;

(2) financial exploitation by a fiduciary;

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

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

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

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

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

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

Sec. 14. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

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

(1) self-neglect;

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

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

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

Sec. 15. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

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

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

Sec. 16. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

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

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

(1) emergency protective services;

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

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

(4) a restraining order or court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to section 518B.01;

(5) a referral for a financial transaction hold under chapter 45A or a protective arrangement under this chapter or chapter 524;

(6) a referral for a representative payee;

(7) a referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under chapter 609;

(8) the appointment or replacement of a guardian or conservator pursuant to sections 524.5-101 to 524.5-502, or guardianship or conservatorship pursuant to chapter 252A when maltreatment has been substantiated and when less restrictive interventions are not sufficient to stop or reduce the risk of serious harm from maltreatment; and

(9) other interventions recommended by a multidisciplinary team under this section.

(c) The county social services agency may seek the protective services interventions under paragraph (b) regardless of the vulnerable adult's voluntary or involuntary participation.

(d) The county social services agency may offer voluntary service interventions to support the vulnerable adult or primary supports to stop, reduce the risk for, or prevent subsequent maltreatment.

Sec. 17. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

Subd. 11i. **County social services agency; legal intervention.** (a) 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 must present the petition with representation by the county attorney. The county must 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 the county has made diligent effort and no other suitable person can be found, a county employee may serve as guardian or conservator.

(b) The county must 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 interests. Any person retaliated against in violation of this subdivision shall have a cause of action against the county and is entitled to reasonable attorney fees and costs of the action if the action is upheld by the court.

(c) The expenses of a legal intervention must be paid by the county in the case of indigent persons under section 524.5-502 and chapter 563.

Sec. 18. Minnesota Statutes 2024, section 626.557, is amended by adding a subdivision to read:

Subd. 11j. **County social services agency; conflict of interest.** (a) A county that identifies a potential conflict of interest under paragraph (c) related to an investigation, assessment, or protective services intervention must coordinate with another county social services agency to delegate the initial county's authority as the lead investigative agency to remediate the potential conflict.

(b) The initial county must notify the commissioner of human services when no other county is available to accept delegation of adult protective services duties. If the commissioner is notified that no other county is available, the commissioner may use the authority under subdivision 9a to determine the county social services agency responsible as lead investigative agency and for adult protective services.

(c) A county social services agency employee or designee must not have:

(1) a personal or family relationship with a party in the investigation or assessment;

(2) a dual relationship, as defined in Code of Federal Regulations, title 45, section 1324.401, with the vulnerable adult;

(3) a personal financial interest or financial relationship with a provider receiving referrals from the employee; or

(4) any other appearance of conflict of interest as determined by the county social services agency.

Sec. 19. Minnesota Statutes 2024, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social ~~service~~ services agency shall maintain appropriate records. Data collected by the county social ~~service~~ services agency under this section while providing adult protective services are welfare data under section 13.46. Investigative data collected under this section are confidential data on individuals or protected nonpublic data as defined under section 13.02. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social ~~service~~ services agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead investigative agency; and

(ix) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) The name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services and county adult protective services must be

maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made for reports under the jurisdiction of the Department of Human Services or the Department of Health and five years after the finding was made for reports under the jurisdiction of county adult protective services;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made for reports under the jurisdiction of the Department of Human Services or the Department of Health and five years after the finding was made for reports under the jurisdiction of county adult protective services;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report for reports under the jurisdiction of the Department of Human Services or the Department of Health and five years from the date of the report for reports under the jurisdiction of county adult protective services.

(e) The commissioners of health and human services shall annually publish on their websites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations.

~~(f) Each lead investigative agency must have a record retention policy.~~

~~(g)~~ (f) Lead investigative agencies, county agencies responsible for adult protective services, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, with a tribal agency, facility, service provider, vulnerable adult, primary support person for a vulnerable adult, emergency management service, financial institution, medical examiner, state licensing board, federal or state agency, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities, if the agency or authority providing the data determines that the data are pertinent and necessary to prevent further maltreatment of a vulnerable adult, to safeguard a vulnerable adult, or for an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, the commissioner of human services as the state Medicaid agency, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative

agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

~~(h)~~ (g) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

~~(i)~~ (h) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

~~(j)~~ (i) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

(j) When a county agency acting as the lead investigative agency is aware the person determined responsible for maltreatment is a guardian or conservator appointed under chapter 524, the county agency must share the final determination with the state judicial branch within 14 calendar days of the determination.

Sec. 20. Minnesota Statutes 2024, section 626.5572, subdivision 2, is amended to read:

Subd. 2. **Abuse.** "Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(c) Any contact with the vulnerable adult that is not therapeutic conduct and a reasonable person would consider a sexual act or any nonconsensual sexual interaction with the vulnerable adult, including but not limited to:

(1) making, viewing, or sharing sexual images or videos with or of the vulnerable adult; and

(2) using oral, written, gestured, or electronic communication that is sexually harassing, including but not limited to unwelcome sexual advances or requests for sexual favors.

~~(c)~~ (d) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

~~(d)~~ (e) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

~~(e)~~ (f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration

parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:

(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

~~(f)~~ (g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

~~(g)~~ (h) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

Sec. 21. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision to read:

Subd. 3a. **Adult protective services.** "Adult protective services" means an adult protection program administered by a county social services agency under the authority of the agency's governing body or delegated to a Tribal government by the commissioner of human services to support adults referred for maltreatment to live safely and with dignity.

Sec. 22. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision to read:

Subd. 3b. **Assessment.** "Assessment" means a structured process conducted by a county social services agency to review the safety, strengths, and needs of an adult referred as vulnerable and maltreated and accepted by the agency for adult protective services and to develop a service plan to stop, prevent, and reduce risk of maltreatment for the adult using standardized tools provided by the Department of Human Services.

Sec. 23. Minnesota Statutes 2024, section 626.5572, subdivision 9, is amended to read:

Subd. 9. **Financial exploitation.** "Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult ~~which results or is likely to result in detriment to the vulnerable adult~~; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by ~~a third person~~ the vulnerable adult for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Sec. 24. Minnesota Statutes 2024, section 626.5572, is amended by adding a subdivision to read:

Subd. 12a. **Investigation.** "Investigation" means activities for fact gathering conducted by the lead investigative agency to make a final determination of maltreatment.

Sec. 25. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949.

(c) The county social ~~service~~ services agency adult protective services or ~~its~~ the agency's designee or a federally recognized Indian Tribe that entered into a contractual agreement with the commissioner of human services to operate adult protective services is the lead investigative agency for all other reports, including but not limited to reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659 or 256B.85.

Sec. 26. Minnesota Statutes 2024, section 626.5572, subdivision 17, is amended to read:

Subd. 17. **Neglect.** (a) "Neglect" means neglect by a caregiver or self-neglect.

(b) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(c) "Self-neglect" means neglect by a vulnerable adult of the vulnerable adult's own food, clothing, shelter, health care, financial management, or other services that are not the

responsibility of a caregiver which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort.

(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; ~~or~~

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; ~~or~~

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(e) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(f) If the findings of an investigation by a lead investigative agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (d), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (d), clause (5), item (iv), (v), or (vi). This must not alter the lead investigative agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (f).

Sec. 27. **REPEALER.**

Minnesota Statutes 2024, section 626.557, subdivision 10, is repealed.

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

ARTICLE 8
CONTINUITY OF CARE

Section 1. **[245D.097] HOUSING ACCOUNTS REQUIRED.**

Subdivision 1. **Housing accounts required.** If payment passes between the license holder or any controlling individual of a licensed program and a service recipient or an entity acting on the service recipient's behalf for the purpose of obtaining or maintaining a living unit in a multifamily housing building where the license holder delivers home and community-based services licensed under this chapter and owns, leases, or has a direct or indirect financial relationship with the property owner, the license holder must for each service recipient:

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

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

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

(4) provide upon demand the same information described in clause (3) to the commissioner.

Subd. 2. **Use of money in the service recipient's account.** The money in the service recipient's account must be used exclusively for expenses associated with the service recipient obtaining or maintaining a living unit in a multifamily housing building.

Subd. 3. **Application.** This section continues to apply when a service recipient chooses to not receive services from the license holder but continues to make payments to the license holder for the purposes of obtaining or maintaining a living unit.

Subd. 4. **Other laws.** The license holder must comply with the requirements of section 245A.04, subdivision 13.

Sec. 2. Minnesota Statutes 2024, section 245D.10, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

(1) the license holder must notify the person or the person's legal representative and case manager in writing of the intended temporary service suspension. If the temporary service

suspension is from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), or from integrated community supports as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), the license holder must also notify the commissioner in writing;

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

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

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

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

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

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

(f) If, based on a review by the person's support team or expanded support team, that team determines the person no longer poses an imminent risk of physical harm to self or others, the person has a right to return to receiving services. If, at the time of the service suspension or at any time during the suspension, the person is receiving treatment related to the conduct that resulted in the service suspension, the support team or expanded support team must consider the recommendation of the licensed health professional, mental health professional, or other licensed professional involved in the person's care or treatment when determining whether the person no longer poses an imminent risk of physical harm to self or others and can return to the program. If the support team or expanded support team makes a determination that is contrary to the recommendation of a licensed professional treating the person, the license holder must document the specific reasons why a contrary decision was made.

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

Subd. 3a. **Service termination.** (a) The license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also

provide support to the person. The policy must include the requirements specified in paragraphs (b) to (f).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the notice must include:

(i) the reason for the action;

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

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

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

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

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

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

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

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

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

(h) For state-operated community-based services, the license holder shall prioritize the capacity created within the existing service site by the termination of services under paragraph (b), clause (7), to serve persons described in section 246C.11, subdivision 4a, paragraph (a), clause (1).

Sec. 4. Minnesota Statutes 2024, section 256B.492, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Community-living setting" means a single-family home or multifamily dwelling unit where a service recipient or a service recipient's family owns or rents and maintains control over the individual unit as demonstrated by a lease agreement. Community-living setting does not include a home or dwelling unit that the ~~service~~ provider of the service recipient's services owns, operates, or leases or in which the ~~service~~ provider of the service recipient's services has a direct or indirect financial interest.

(c) "Controlling individual" has the meaning given in section 245A.02, subdivision 5a.

(d) "License holder" has the meaning given in section 245A.02, subdivision 9.

Sec. 5. Minnesota Statutes 2024, section 256B.492, subdivision 3, is amended to read:

Subd. 3. **Community-living settings.** (a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in community-living settings. Community-living settings must meet the requirements of subdivision 2, paragraph (a), clause (1).

(b) For the purposes of this section, direct financial interest exists if payment passes between the license holder or any controlling individual of a licensed program and the service recipient or an entity acting on the service recipient's behalf for the purpose of obtaining or maintaining a dwelling. For the purposes of this section, indirect financial interest exists if the license holder or any controlling individual of a licensed program has an ownership or investment interest in the entity that owns, operates, leases, or otherwise receives payment from the service recipient or an entity acting on the service recipient's behalf for the purpose of obtaining or maintaining a dwelling. Neither a direct nor an indirect financial interest exists if the service recipient is receiving services from a license holder or a licensed program that is not the license holder or a licensed program that owns, operates, leases, or has a direct or indirect financial interest in the setting in which the service recipient's services are being delivered.

(c) To ensure a service recipient or the service recipient's family maintains control over the home or dwelling unit, community-living settings are subject to the following requirements:

(1) service recipients must not be required to receive services or share services;

(2) service recipients must not be required to have a disability or specific diagnosis to live in the community-living setting;

(3) service recipients may hire service providers of their choice;

(4) service recipients may choose whether to share their household and with whom;

(5) the home or multifamily dwelling unit must include living, sleeping, bathing, and cooking areas;

(6) service recipients must have lockable access and egress;

(7) service recipients must be free to receive visitors and leave the settings at times and for durations of their own choosing;

(8) leases must comply with chapter 504B;

(9) landlords must not charge different rents to tenants who are receiving home and community-based services; and

(10) access to the greater community must be easily facilitated based on the service recipient's needs and preferences.

(d) Nothing in this section prohibits a service recipient from having another person or entity not affiliated with the service provider cosign a lease. Nothing in this section prohibits a service recipient, during any period in which a service provider has cosigned the service recipient's lease, from modifying services with an existing cosigning service provider and, subject to the approval of the landlord, maintaining a lease cosigned by the service provider. Nothing in this section prohibits a service recipient, during any period in which a service provider has cosigned the service recipient's lease, from terminating services with the cosigning service provider, receiving services from a new service provider, or, subject to the approval of the landlord, maintaining a lease cosigned by the new service provider.

(e) A lease cosigned by a service provider meets the requirements of paragraph (b) if the service recipient and service provider develop and implement a transition plan which must provide that, within two years of cosigning the initial lease, the service provider shall transfer the lease to the service recipient and other cosigners, if any.

(f) In the event the landlord has not approved the transfer of the lease within two years of the service provider cosigning the initial lease, the service provider must submit a time-limited extension request to the commissioner of human services to continue the cosigned lease arrangement. The extension request must include:

(1) the reason the landlord denied the transfer;

(2) the plan to overcome the denial to transfer the lease;

(3) the length of time needed to successfully transfer the lease, not to exceed an additional two years;

(4) a description of how the transition plan was followed, what occurred that led to the landlord denying the transfer, and what changes in circumstances or condition, if any, the service recipient experienced; and

(5) a revised transition plan to transfer the cosigned lease between the service provider and the service recipient to the service recipient.

(g) The commissioner must approve an extension under paragraph (f) within sufficient time to ensure the continued occupancy by the service recipient.

ARTICLE 9
MISCELLANEOUS POLICY

Section 1. Minnesota Statutes 2025 Supplement, section 15.471, subdivision 6, is amended to read:

Subd. 6. **Party.** (a) Except as modified by paragraph (b), "party" means a person named or admitted as a party, or seeking and entitled to be admitted as a party, in a court action or contested case proceeding, or a person admitted by an administrative law judge for limited purposes, and who is:

(1) an unincorporated business, partnership, corporation, association, or organization, having not more than 500 employees at the time the civil action was filed or the contested case proceeding was initiated; and

(2) an unincorporated business, partnership, corporation, association, or organization whose annual revenues did not exceed ~~$7,000,000~~ $13,500,000 at the time the civil action was filed or the contested case proceeding was initiated.

(b) ~~"~~Party~~"~~ also includes a partner, officer, shareholder, member, or owner of an entity described in paragraph (a), clauses (1) and (2).

(c) ~~"~~Party~~"~~ does not include a person providing services pursuant to licensure or reimbursement on a cost basis by ~~the Department of Health,~~ the Department of Human Services~~,~~ or Direct Care and Treatment when that person is named or admitted or seeking to be admitted as a party in a matter which involves the licensing or reimbursement rates, procedures, or methodology applicable to those services.

Sec. 2. Minnesota Statutes 2024, section 97B.001, subdivision 4, is amended to read:

Subd. 4. **Entering posted land prohibited; signs.** (a) Except as provided in subdivision 6, a person may not:

(1) enter, for outdoor recreation purposes, any land that is posted under this subdivision without first obtaining permission of the owner, occupant, or lessee; or

(2) knowingly enter, for outdoor recreation purposes, any land that is posted under this subdivision without first obtaining permission of the owner, occupant, or lessee. A person who violates this clause is subject to the penalty provided in section 97A.315, subdivision 1, paragraph (b).

(b) The owner, occupant, or lessee of private land, or an authorized manager of public land may prohibit outdoor recreation on the land by posting signs once each year that:

(1) state "no trespassing" or similar terms;

(2) display letters at least two inches high;

(3) either:

(i) are signed by the owner, occupant, lessee, or authorized manager; or

(ii) include the legible name and telephone number of the owner, occupant, lessee, or authorized manager; and

(4) either:

(i) are at intervals of 1,000 feet or less along the boundary of the area, or in a wooded area where boundary lines are not clear, at intervals of 500 feet or less; or

(ii) mark the primary corners of each parcel of land and access roads and trails at the point of entrance to each parcel of land except that corners only accessible through agricultural land need not be posted.

(c) A person may not ~~erect a sign that prohibits outdoor recreation or trespassing~~ act under paragraph (b) or (d) where the person does not have a property right, title, or interest to use the land.

(d) As an alternative to posting signage under paragraph (b), the owner, occupant, or lessee of private land, or an authorized manager of public land, may prohibit outdoor recreation on the land by:

(1) applying purple paint to trees along the perimeter of the area to which the person wants to prohibit entrance. Paint applied under this paragraph must be applied:

(i) at least three feet off the ground;

(ii) to trees that are at least one inch wide; and

(iii) in a strip that is at least eight inches tall; and

(2) posting signs once each year that mark the primary corners of the area to which the person wants to prohibit entrance.

Sec. 3. Minnesota Statutes 2024, section 256B.04, subdivision 24, is amended to read:

Subd. 24. **Medicaid waiver requests and state plan amendments; notice; public comments.** (a) The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance at least 30 days before submitting a new Medicaid waiver request to the federal government.

(b) Prior to submitting any Medicaid waiver request or Medicaid state plan amendment to the federal government for approval, the commissioner shall publish the text of the waiver request or state plan amendment, and a summary of and explanation of the need for the request, on the agency's website and provide a 30-day public comment period. The commissioner shall notify the public of the availability of this information through the agency's electronic subscription service. The commissioner shall publish the text of all public comments on the agency's website and consider public comments when preparing the final waiver request or state plan amendment that is to be submitted to the federal government for approval.

(c) The commissioner shall also publish on the agency's website notice of any federal decision related to the state request for approval, within 30 days of the decision. This notice must describe any modifications to the state request that have been agreed to by the commissioner as a condition of receiving federal approval.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to read:

Subd. 24a. **Medicaid waiver requests and state plan amendments; prohibited actions.** Without prior legislative authorization under subdivision 24b, the commissioner must not take the following actions:

(1) terminate a medical assistance program, waiver, or benefit; or

(2) request federal assistance with terminating a medical assistance program, waiver, or benefit.

Sec. 5. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to read:

Subd. 24b. **Medicaid waiver requests and state plan amendments; legislative authorization.** (a) The commissioner must notify the chairs and ranking minority members of the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance at least 60 days prior to taking one of the actions listed under subdivision 24a.

(b) Upon notification, the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance must schedule a hearing on the proposed action within 30 days of notification.

(c) If all of the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance vote to advise the commissioner that a proposed action should not be implemented as proposed, the commissioner must not implement the proposed action until the legislature adjourns the annual legislative session that began after the vote of the committees. A committee vote under this subdivision must be by a majority of the committee.

Sec. 6. Minnesota Statutes 2024, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets meets the definition of disabled under the Supplemental Security Income program; and

(2) pays a premium and other obligations under paragraph (d).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income, be receiving an unemployment insurance benefit under chapter 268 that the person began receiving while eligible under this subdivision, or be receiving family and medical leave benefits under chapter 268B that the person began receiving while eligible under this subdivision. A person who is self-employed must file and pay all applicable taxes. Any spousal income shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who would otherwise be ineligible and be disenrolled due to one of the following circumstances may retain eligibility for up to four consecutive months after a month of job loss if the person:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, advanced practice registered nurse, or physician assistant; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income.

To receive a four-month extension of continued eligibility under this paragraph, enrollees must verify the medical condition or provide notification of job loss, continue to meet all other eligibility requirements, and continue to pay all calculated premium costs.

(d) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(e) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(f) Any required premium shall be determined at application and redetermined at the enrollee's 12-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within 30 days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the

change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next 12-month review.

(g) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. The commissioner must not determine that good cause exists for a month for which the premium has already been paid. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(i) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

(j) The commissioner is authorized to determine that a premium amount was calculated or billed in error, make corrections to financial records and billing systems, and refund premiums collected in error.

Sec. 7. Minnesota Statutes 2024, section 256B.0625, subdivision 4, is amended to read:

Subd. 4. **Outpatient and physician-directed clinic services.** Medical assistance covers outpatient hospital or physician-directed clinic services. ~~The~~ All services provided by physician-directed clinic staff ~~shall include at least two physicians and all services shall~~ must be ~~provided~~ under the ~~direct supervision~~ direction of a physician. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. "Emergency services" means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could

lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 8. **DIRECTION TO COMMISSIONER; RULEMAKING.**

The commissioner of human services must amend Minnesota Rules, part 9505.2165, subpart 4, item C, to remove the citation to United States Code, title 42, section 1320a-7b(b)(3)(D), and insert a citation to United States Code, title 42, section 1320a-7b(b). The commissioner may use the procedure under Minnesota Statutes, section 14.388, subdivision 1, clause (3), for changes to Minnesota Rules pursuant to this section. Minnesota Statutes, section 14.386, does not apply to rules adopted pursuant to this section except as provided under Minnesota Statutes, section 14.388.

Sec. 9. **DIRECTION TO COMMISSIONER; UNREDACTED INITIAL OPTUM REPORTS.**

(a) For purposes of this section, "initial Optum reports" means the reports produced by Optum, Inc., under contract with the Department of Human Services and announced in the news release from the department on February 6, 2026.

(b) Notwithstanding any law to the contrary, upon a joint request by the chairs and ranking minority members of a legislative committee with jurisdiction over human services policy and finance, the commissioner of human services must immediately release the initial Optum reports to the members of that legislative committee in the reports' entirety without redactions or edits, except for redactions requested by Optum to protect proprietary information. Legislators or legislative staff who receive initial Optum reports under this section must not disseminate or publicize any not public data, as defined in Minnesota Statutes, section 13.02, subdivision 8a, that the reports contain.

EFFECTIVE DATE. This section is effective 14 days following final enactment.

Sec. 10. **OPTUM PROHIBITED FROM DISSEMINATING PRIVATE DATA.**

Optum, Inc., must not sell, share, or disseminate any private data on individuals, as defined in Minnesota Statutes, section 13.02, subdivision 12, that Optum receives under or

incidental to Optum's contract or engagement with the Department of Human Services pursuant to the governor's Executive Order No. 25-10.

APPENDIX
Article locations for S0476-4

ARTICLE 1	DIRECT CARE AND TREATMENT POLICY	Page.Ln 2.20
ARTICLE 2	DIRECT CARE AND TREATMENT	Page.Ln 19.17
ARTICLE 3	DEPARTMENT OF HEALTH POLICY	Page.Ln 23.1
ARTICLE 4	AGING AND DISABILITY SERVICES POLICY	Page.Ln 46.3
ARTICLE 5	BEHAVIORAL HEALTH	Page.Ln 94.2
ARTICLE 6	DEPARTMENT OF HUMAN SERVICES HOUSING AND SUPPORT SERVICES	Page.Ln 137.14
ARTICLE 7	MALTREATMENT OF VULNERABLE ADULTS	Page.Ln 138.16
ARTICLE 8	CONTINUITY OF CARE	Page.Ln 163.1
ARTICLE 9	MISCELLANEOUS POLICY	Page.Ln 171.8

245A.03 WHO MUST BE LICENSED.

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, which does not include child foster residence settings with residential program certifications for compliance with the Family First Prevention Services Act under section 245A.25, subdivision 1, paragraph (a), or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a child foster residence setting that was previously exempt from the licensing moratorium under this paragraph has its Family First Prevention Services Act certification rescinded under section 245A.25, subdivision 9, or if a family adult foster care home license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) a license for a person in a foster care setting that is not the primary residence of the license holder and where at least 80 percent of the residents are 55 years of age or older;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital-level care; or

(5) new community residential setting licenses determined necessary by the commissioner for people affected by the closure of homes with a capacity of five or six beds currently licensed as supervised living facilities licensed under Minnesota Rules, chapter 4665, but not designated as intermediate care facilities. This exception is available until June 30, 2025.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) must be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available data required by section 144A.351, and other data and information must be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary

limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

254B.052 PEER RECOVERY SUPPORT SERVICES REQUIREMENTS.

Subd. 6. **Monetary recovery.** Peer recovery support services not provided in accordance with this section are subject to monetary recovery under section 256B.064 as money improperly paid.

256B.051 HOUSING STABILIZATION SERVICES.

Subdivision 1. **Purpose.** Housing stabilization services are established to provide housing stabilization services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide housing stabilization services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section.

(c) "At-risk of homelessness" means (1) an individual that is faced with a set of circumstances likely to cause the individual to become homeless, or (2) an individual previously homeless, who will be discharged from a correctional, medical, mental health, or treatment center, who lacks sufficient resources to pay for housing and does not have a permanent place to live.

(d) "Commissioner" means the commissioner of human services.

(e) "Employee of an agency" or "employee" means any person who is employed by an agency temporarily, part time, or full time and who performs work for at least 80 hours in a year for that agency in Minnesota. Employee does not include an independent contractor.

(f) "Homeless" means an individual or family lacking a fixed, adequate nighttime residence.

(g) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria used by the title 11 program of the Social Security Act, United States Code, title 42, section 416, paragraph (i), item (1); or

(2) an individual who meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

(h) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause (3), and the Minnesota Security Hospital as defined in section 253.20.

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing stabilization services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has income at or below 150 percent of the federal poverty level;

(4) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(5) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301 (c); and

(6) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under chapter 256S or section 256B.092 or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, subdivisions 17 to 21, 23, 24, and 29 to 31, using a format established by the commissioner;

(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

Subd. 5. **Housing stabilization services.** (a) Housing stabilization services include housing transition services, housing and tenancy sustaining services, housing consultation services, and housing transition costs.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) Housing consultation services assist an individual with developing a person-centered plan when the individual is not eligible to receive person-centered planning through any other service.

(e) Housing transition costs are available to persons transitioning from a provider-controlled setting to the person's own home and include:

(1) security deposits; and

(2) essential furnishings and supplies.

Subd. 6. **Agency qualifications and duties.** An agency is eligible for reimbursement under this section only if the agency:

(1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 6a;

(2) is enrolled as a medical assistance Minnesota health care program provider and meets all applicable provider standards and requirements;

(3) demonstrates compliance with federal and state laws and policies for housing stabilization services as determined by the commissioner;

(4) complies with background study requirements under chapter 245C and maintains documentation of background study requests and results;

(5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is $300,000 or less, the provider agency must purchase a surety bond of $50,000. If the provider's medical assistance revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) directly provides housing stabilization services using employees of the agency and not by using a subcontractor or reporting agent;

(7) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training; and

(8) completes compliance training as required under subdivision 6b.

Subd. 6a. **Pre-enrollment risk assessment.** (a) Prior to enrolling a housing stabilization services agency, the commissioner must complete a pre-enrollment risk assessment of the agency seeking to enroll to confirm the agency's eligibility and the agency's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential agency's history of performing services similar to those required by this section;

(2) whether the services require the potential agency to perform duties at a significantly increased scale and, if so, whether the potential agency has the capability and organizational capacity to do so;

(3) the potential agency's financial information and internal controls; and

(4) the potential agency's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential agency does not have a history of performing similar duties, the potential agency does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential agency ineligible and deny or rescind enrollment. A potential agency may appeal a decision regarding its eligibility in writing within 30 business days. The commissioner must notify each potential agency of the commissioner's final decision regarding its eligibility.

(c) This subdivision is effective July 1, 2025. Any housing stabilization services provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Subd. 6b. **Requirements for provider enrollment.** (a) Effective January 1, 2027, to enroll as a housing stabilization services provider agency, an agency must require all owners of the agency who are active in the day-to-day management and operations of the agency and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) enrollment requirements;

(3) provider program integrity, including fraud prevention, detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the agency. If an individual moves to another housing stabilization services provider agency and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any housing stabilization services provider agency enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing stabilization services under this section.

Subd. 8. **Documentation requirements.** (a) An agency must document delivery of all services. The agency must collect and maintain the required information either electronically or in paper form and must produce the documents containing the information upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the full name of the service recipient;

(2) the date the documentation occurred;

(3) the day, month, and year the service was provided;

(4) the start and stop times with a.m. and p.m. designations, except for housing consultation services;

(5) the service name or description of the service provided for each date of service;

(6) the name, signature, and title, if any, of the employee of the agency that provided the service. If the service is provided by multiple employees, the agency may designate an employee responsible for verifying services and completing the documentation required by this paragraph;

(7) the signature of the service recipient and a statement that the recipient's signature is verification of the accuracy of the service documentation; and

(8) a statement that it is a federal crime to provide false information on housing stabilization services billings for medical assistance payments.

Subd. 9. **Service limits.** (a) Housing stabilization services must not exceed the limits in clauses (1) to (4):

(1) housing transition services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing and tenancy sustaining services;

(2) housing and tenancy sustaining services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing transition services;

(3) housing consultation services are available once annually per recipient and must be provided in person. Additional sessions of housing consultation services may be authorized by the commissioner if the recipient becomes homeless, the recipient experiences a significant change in condition that impacts the recipient's housing, or the recipient requests an update or change to the recipient's plan; and

(4) housing transition costs are limited to $3,000 annually.

(b) Remote support cannot be used for more than a total of 20 percent of all housing transition services and housing and tenancy sustaining services provided to a recipient in a calendar month and is limited to audio-only and accessible video-based platforms. A recipient may refuse, stop, or suspend the use of remote support at any time.

Subd. 10. **Service limit exceptions.** If a recipient requires services exceeding the limits described in subdivision 9, a provider may request authorization for additional hours in a format prescribed by the commissioner. Requests must specify the number of additional hours being requested to meet the recipient's needs and include sufficient documentation to justify the increase to billable hours. Exceptions to service limits are not allowed on the sole basis of changing providers and are limited to recipients who:

(1) become or are at risk of becoming homeless or institutionalized due to a significant change in condition;

(2) have a history of long-term homelessness;

(3) have a history of domestic violence; or

(4) have a criminal background that is a barrier to obtaining housing.

256B.0759 SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.

Subd. 2. **Provider participation.** (a) Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter, are licensed as a hospital under sections 144.50 to 144.581, and provide only ASAM 3.7 medically monitored inpatient level of care are not required to enroll as demonstration project providers. Programs meeting these criteria must submit evidence of providing the required level of care to the commissioner to be exempt from enrolling in the demonstration.

(d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(f) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with Tribal Nations to discuss participation in the substance use disorder demonstration project.

(g) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

(1) the provider attests that during the time period for which the provider is seeking the rate enhancement, the provider took meaningful steps in their plan approved by the commissioner to meet the demonstration project requirements in subdivision 3; and

(2) the provider submits attestation and evidence, including all information requested by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in a format required by the commissioner.

(h) The commissioner may recoup any rate enhancements paid under paragraph (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

256B.5012 ICF/DD PAYMENT SYSTEM IMPLEMENTATION.

Subd. 4. **ICF/DD rate increases beginning July 1, 2001, and July 1, 2002.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 3.5 percent. Of this adjustment, two-thirds must be used as provided under paragraph (b) and one-third must be used for operating costs.

(b) The adjustment under this paragraph must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase must be used only for wage and benefit increases implemented on or after the first day of the rate year and must not be used for increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding June 30. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the payment rate adjustment provided under paragraph (b). The application must be made to the commissioner and contain a plan by which the facility will distribute the adjustment in paragraph (b) to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to

by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2002, and March 31, 2003, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Subd. 5. **Rate increase effective June 1, 2003.** For rate periods beginning on or after June 1, 2003, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $3 per day. The increase shall not be subject to any annual percentage increase.

Subd. 6. **ICF/DD rate increases October 1, 2005, and October 1, 2006.** (a) For the rate periods beginning October 1, 2005, and October 1, 2006, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 2.2553 percent.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for employees, except for administrative and central office employees. 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date. The wage adjustment eligible employees may receive may vary based on merit, seniority, or other factors determined by the provider.

(c) For each facility, the commissioner shall make available an adjustment, based on occupied beds, using the percentage specified in paragraph (a) multiplied by the total payment rate, including variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the portion of the payment rate adjustment provided under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the facility will distribute the funds according to paragraph (b). For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2006, and December 31, 2006, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate period that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Subd. 7. **ICF/DD rate increases effective October 1, 2007, and October 1, 2008.** (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner shall make available to each facility reimbursed under this section operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2008. For each facility, the commissioner shall make available an adjustment, based on occupied

beds, using the percentage specified in this paragraph multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding day. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12. A facility whose payment rates are governed by closure agreements or receivership agreements is not eligible for an adjustment otherwise granted under this subdivision.

(b) Seventy-five percent of the money resulting from the rate adjustments under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the facility or exercises control over the facility; and

(3) persons paid by the facility under a management contract.

(c) Two-thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the facility on or after the effective date of the rate adjustments, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation-related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustments under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to facilities effective October 1 of each year.

(f) Facilities may apply for the portion of the rate adjustments under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustments, and the facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustments. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the facility will implement to use the funds available in clause (1);

(3) a description of how the facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, email address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with requirements in clauses (1) to (4):

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the facility's payroll period that includes October 1 of each year shall be allowed if they were not used in the prior year's application and they meet the requirements of paragraphs (b) and (c);

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1 of the year in which the rate adjustments are effective and prior to April 1 of the following year; and

(4) for facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, as regards members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustments under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustments shall be effective October 1 of each year. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

Subd. 8. **ICF/DD rate decreases effective July 1, 2009.** Effective July 1, 2009, the commissioner shall decrease each facility reimbursed under this section operating payment adjustments equal to 2.58 percent of the operating payment rates in effect on June 30, 2009. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in subdivision 7.

Subd. 9. **ICF/DD rate increase effective July 1, 2011; Clearwater County.** Effective July 1, 2011, the commissioner shall increase the daily rate to $138.23 at an intermediate care facility for 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:

(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 by Laws 2026, chapter 95, article 4, section 42

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).