

1.1 A bill for an act

1.2 relating to human services; modifying provisions related to health care, the

1.3 Department of Human Services Office of Inspector General, human services

1.4 background studies, uniform service standards, aging and disability services,

1.5 administrative reform, children and families, and grant programs; requiring reports;

1.6 appropriating money; amending Minnesota Statutes 2024, sections 16A.103, by

1.7 adding a subdivision; 62M.07, subdivision 2; 142B.01, subdivision 8; 142E.16,

1.8 by adding a subdivision; 245.095, subdivisions 2, 5, by adding a subdivision;

1.9 245.096; 245.735, subdivision 6; 245A.02, subdivisions 5a, 13; 245A.03,

1.10 subdivision 7, by adding subdivisions; 245A.042, by adding a subdivision;

1.11 245A.043, subdivision 2; 245A.07, subdivision 2a; 245A.10, by adding a

1.12 subdivision; 245A.65, subdivision 1a; 245C.03, subdivisions 1, 3a, 9, by adding

1.13 subdivisions; 245D.081, subdivision 3; 245D.261, subdivision 3; 245G.03,

1.14 subdivision 1; 245I.011, subdivisions 3, 5, by adding a subdivision; 245I.02,

1.15 subdivisions 33, 39, by adding subdivisions; 245I.03, subdivision 4, by adding a

1.16 subdivision; 245I.06, subdivisions 1, 2; 245I.07; 245I.10, subdivisions 6, 8, by

1.17 adding a subdivision; 256.01, by adding a subdivision; 256B.02, by adding a

1.18 subdivision; 256B.04, subdivision 10; 256B.05, subdivision 1; 256B.0623,

1.19 subdivisions 1, 3, 12; 256B.0624, subdivisions 1, 4, by adding a subdivision;

1.20 256B.0625, subdivision 17b, by adding a subdivision; 256B.064, subdivisions 1b,

1.21 1c, 1d, 2, 3, 4, 5, by adding subdivisions; 256B.073, subdivisions 1, 2, 3, 5, by

1.22 adding subdivisions; 256B.0911, subdivision 32; 256B.0943, subdivision 2;

1.23 256B.0949, subdivision 17, by adding a subdivision; 256B.4912, subdivision 12,

1.24 by adding a subdivision; 256B.4914, subdivision 6, by adding subdivisions;

1.25 256B.492, by adding a subdivision; 256B.69, subdivisions 5a, 37, by adding a

1.26 subdivision; 256I.03, subdivision 10a; 256I.04, subdivisions 1, 2f; 256I.05,

1.27 subdivision 11; 256S.21, by adding subdivisions; Minnesota Statutes 2025

1.28 Supplement, sections 15.013, by adding a subdivision; 245A.03, subdivisions 2,

1.29 7a; 245A.04, subdivisions 1, 7; 245A.043, subdivision 2a; 245A.05; 245A.07,

1.30 subdivision 3; 245A.10, subdivisions 3, 4; 245C.13, subdivision 2; 245C.16,

1.31 subdivision 1; 245I.04, subdivisions 5, 17; 256.01, subdivision 2; 256B.04,

1.32 subdivision 21; 256B.051, subdivision 6; 256B.0625, subdivisions 5m, 17;

1.33 256B.064, subdivision 1a; 256B.0659, subdivision 21; 256B.0701, subdivision 9;

1.34 256B.0759, subdivision 4; 256B.0943, subdivisions 3, 12; 256B.0949, subdivisions

1.35 2, 16; 256B.4914, subdivision 5a; 256B.85, subdivisions 12, 17a; 256I.04,

1.36 subdivision 2a; 260E.14, subdivision 1; 626.5572, subdivision 13; proposing

1.37 coding for new law in Minnesota Statutes, chapters 245A; 245I; 256B; 256I;

1.38 repealing Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b,

2.1 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, 8; 245C.03, subdivision 7; 245I.20,  
2.2 subdivision 9; 245I.23, subdivision 23; 256B.0623, subdivisions 2, 4, 5, 6, 9;  
2.3 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, 11; 256B.073, subdivision  
2.4 4; 256B.0943, subdivisions 4, 5, 5a, 6, 7, 11; 256B.4914, subdivision 6c; Minnesota  
2.5 Statutes 2025 Supplement, sections 245.735, subdivisions 3, 4d; 245A.042,  
2.6 subdivision 5; 245A.10, subdivision 3a; 256B.0943, subdivisions 1, 9.

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

2.8 **ARTICLE 1**  
2.9 **HEALTH CARE**

2.10 Section 1. Minnesota Statutes 2025 Supplement, section 15.013, is amended by adding a  
2.11 subdivision to read:

2.12 Subd. 7. **Exemption.** Nothing in this section modifies, supersedes, limits, or expands  
2.13 the authority of the commissioner of human services to impose sanctions under section  
2.14 256B.064.

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

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

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

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

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

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

3.1 (4) services that currently have a rating of A or B from the United States Preventive  
3.2 Services Task Force, immunizations recommended by the Advisory Committee on  
3.3 Immunization Practices of the Centers for Disease Control and Prevention, or preventive  
3.4 services and screenings provided to women as described in Code of Federal Regulations,  
3.5 title 45, section 147.130;

3.6 (5) pediatric hospice services provided by a hospice provider licensed under sections  
3.7 144A.75 to 144A.755; and

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

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

3.12 (b) Nothing in this subdivision prohibits a utilization review organization, health plan  
3.13 company, or claims administrator from conducting or requiring prior authorization to  
3.14 authorize services by a provider type designated as high-risk under section 256B.044,  
3.15 subdivision 1.

3.16 Sec. 3. Minnesota Statutes 2024, section 142B.01, subdivision 8, is amended to read:

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

3.20 (1) each officer of the organization, including the chief executive officer and chief  
3.21 financial officer;

3.22 (2) the individual designated as the authorized agent under section 142B.10, subdivision  
3.23 1, paragraph (b);

3.24 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~  
3.25 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

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

3.31 (b) Controlling individual does not include:

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

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

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

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

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

4.13 (4) an individual who is a member of an organization exempt from taxation under section  
4.14 290.05, unless the individual is also an officer, owner, or managerial official of the program  
4.15 or owns any of the beneficial interests not excluded in this subdivision. This clause does  
4.16 not exclude from the definition of controlling individual an organization that is exempt from  
4.17 taxation; or

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

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

4.26 Sec. 4. Minnesota Statutes 2024, section 245.095, is amended by adding a subdivision to  
4.27 read:

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

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

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

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

5.5 (1) each officer of the organization, including the chief executive officer and chief  
5.6 financial officer;

5.7 (2) the individual designated as the authorized agent under section 245A.04, subdivision  
5.8 1, paragraph (b);

5.9 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~  
5.10 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

5.14 (b) Controlling individual does not include:

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

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

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

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

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

5.27 (4) an individual who is a member of an organization exempt from taxation under section  
5.28 290.05, unless the individual is also an officer, owner, or managerial official of the program  
5.29 or owns any of the beneficial interests not excluded in this subdivision. This clause does  
5.30 not exclude from the definition of controlling individual an organization that is exempt from  
5.31 taxation; or

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

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

6.9 Sec. 6. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 1, is amended  
6.10 to read:

6.11 Subdivision 1. **Application for licensure.** (a) An individual, organization, or government  
6.12 entity that is subject to licensure under section 245A.03 must apply for a license. The  
6.13 application must be made on the forms and in the manner prescribed by the commissioner.  
6.14 The commissioner shall provide the applicant with instruction in completing the application  
6.15 and provide information about the rules and requirements of other state agencies that affect  
6.16 the applicant. An applicant seeking licensure in Minnesota with headquarters outside of  
6.17 Minnesota must have a program office located within 30 miles of the Minnesota border.  
6.18 An applicant who intends to buy or otherwise acquire a program or services licensed under  
6.19 this chapter that is owned by another license holder must apply for a license under this  
6.20 chapter and comply with the application procedures in this section and section 245A.043.  
6.21 A license issued pursuant to a change of ownership under section 245A.043 is not subject  
6.22 to any moratorium imposed under section 245A.03, subdivision 7 or 7a, provided the change  
6.23 of ownership does not result in an increase in licensed capacity or service scope.

6.24 The commissioner shall act on the application within 90 working days after a complete  
6.25 application and any required reports have been received from other state agencies or  
6.26 departments, counties, municipalities, or other political subdivisions. The commissioner  
6.27 shall not consider an application to be complete until the commissioner receives all of the  
6.28 required information. If the applicant or a controlling individual is the subject of a pending  
6.29 administrative, civil, or criminal investigation, the application is not complete until the  
6.30 investigation has closed or the related legal proceedings are complete.

6.31 When the commissioner receives an application for initial licensure that is incomplete  
6.32 because the applicant failed to submit required documents or that is substantially deficient  
6.33 because the documents submitted do not meet licensing requirements, the commissioner  
6.34 shall provide the applicant written notice that the application is incomplete or substantially

7.1 deficient. In the written notice to the applicant the commissioner shall identify documents  
7.2 that are missing or deficient and give the applicant 45 days to resubmit a second application  
7.3 that is substantially complete. An applicant's failure to submit a substantially complete  
7.4 application after receiving notice from the commissioner is a basis for license denial under  
7.5 section 245A.043.

7.6 (b) An application for licensure must identify all controlling individuals as defined in  
7.7 section 245A.02, subdivision 5a, and must designate one individual to be the authorized  
7.8 agent. The application must be signed by the authorized agent and must include the authorized  
7.9 agent's first, middle, and last name; mailing address; and email address. By submitting an  
7.10 application for licensure, the authorized agent consents to electronic communication with  
7.11 the commissioner throughout the application process. The authorized agent must be  
7.12 authorized to accept service on behalf of all of the controlling individuals. A government  
7.13 entity that holds multiple licenses under this chapter may designate one authorized agent  
7.14 for all licenses issued under this chapter or may designate a different authorized agent for  
7.15 each license. Service on the authorized agent is service on all of the controlling individuals.  
7.16 It is not a defense to any action arising under this chapter that service was not made on each  
7.17 controlling individual. The designation of a controlling individual as the authorized agent  
7.18 under this paragraph does not affect the legal responsibility of any other controlling individual  
7.19 under this chapter.

7.20 (c) An applicant or license holder must have a policy that prohibits license holders,  
7.21 employees, subcontractors, and volunteers, when directly responsible for persons served  
7.22 by the program, from abusing prescription medication or being in any manner under the  
7.23 influence of a chemical that impairs the individual's ability to provide services or care. The  
7.24 license holder must train employees, subcontractors, and volunteers about the program's  
7.25 drug and alcohol policy before the employee, subcontractor, or volunteer has direct contact,  
7.26 as defined in section 245C.02, subdivision 11, with a person served by the program.

7.27 (d) An applicant and license holder must have a program grievance procedure that permits  
7.28 persons served by the program and their authorized representatives to bring a grievance to  
7.29 the highest level of authority in the program.

7.30 (e) The commissioner may limit communication during the application process to the  
7.31 authorized agent or the controlling individuals identified on the license application and for  
7.32 whom a background study was initiated under chapter 245C. Upon implementation of the  
7.33 provider licensing and reporting hub, applicants and license holders must use the hub in the  
7.34 manner prescribed by the commissioner. The commissioner may require the applicant,  
7.35 except for child foster care, to demonstrate competence in the applicable licensing

8.1 requirements by successfully completing a written examination. The commissioner may  
8.2 develop a prescribed written examination format.

8.3 (f) When an applicant is an individual, the applicant must provide:

8.4 (1) the applicant's taxpayer identification numbers including the Social Security number  
8.5 or Minnesota tax identification number, and federal employer identification number if the  
8.6 applicant has employees;

8.7 (2) at the request of the commissioner, a copy of the most recent filing with the secretary  
8.8 of state that includes the complete business name, if any;

8.9 (3) if doing business under a different name, the doing business as (DBA) name, as  
8.10 registered with the secretary of state;

8.11 (4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique  
8.12 Minnesota Provider Identifier (UMPI) number; and

8.13 (5) at the request of the commissioner, the notarized signature of the applicant or  
8.14 authorized agent.

8.15 (g) When an applicant is an organization, the applicant must provide:

8.16 (1) the applicant's taxpayer identification numbers including the Minnesota tax  
8.17 identification number and federal employer identification number;

8.18 (2) at the request of the commissioner, a copy of the most recent filing with the secretary  
8.19 of state that includes the complete business name, and if doing business under a different  
8.20 name, the doing business as (DBA) name, as registered with the secretary of state;

8.21 (3) the first, middle, and last name, and address for all individuals who will be controlling  
8.22 individuals, including all officers, owners, and managerial officials as defined in section  
8.23 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant  
8.24 for each controlling individual;

8.25 (4) if applicable, the applicant's NPI number and UMPI number;

8.26 (5) the documents that created the organization and that determine the organization's  
8.27 internal governance and the relations among the persons that own the organization, have  
8.28 an interest in the organization, or are members of the organization, in each case as provided  
8.29 or authorized by the organization's governing statute, which may include a partnership  
8.30 agreement, bylaws, articles of organization, organizational chart, and operating agreement,  
8.31 or comparable documents as provided in the organization's governing statute; and

8.32 (6) the notarized signature of the applicant or authorized agent.

9.1 (h) When the applicant is a government entity, the applicant must provide:

9.2 (1) the name of the government agency, political subdivision, or other unit of government  
9.3 seeking the license and the name of the program or services that will be licensed;

9.4 (2) the applicant's taxpayer identification numbers including the Minnesota tax  
9.5 identification number and federal employer identification number;

9.6 (3) a letter signed by the manager, administrator, or other executive of the government  
9.7 entity authorizing the submission of the license application; and

9.8 (4) if applicable, the applicant's NPI number and UMPI number.

9.9 (i) At the time of application for licensure or renewal of a license under this chapter, the  
9.10 applicant or license holder must acknowledge on the form provided by the commissioner  
9.11 if the applicant or license holder elects to receive any public funding reimbursement from  
9.12 the commissioner for services provided under the license that:

9.13 (1) the applicant's or license holder's compliance with the provider enrollment agreement  
9.14 or registration requirements for receipt of public funding may be monitored by the  
9.15 commissioner as part of a licensing investigation or licensing inspection; and

9.16 (2) noncompliance with the provider enrollment agreement or registration requirements  
9.17 for receipt of public funding that is identified through a licensing investigation or licensing  
9.18 inspection, or noncompliance with a licensing requirement that is a basis of enrollment for  
9.19 reimbursement for a service, may result in:

9.20 (i) a correction order or a conditional license under section 245A.06, or sanctions under  
9.21 section 245A.07;

9.22 (ii) nonpayment of claims submitted by the license holder for public program  
9.23 reimbursement;

9.24 (iii) recovery of payments made for the service;

9.25 (iv) disenrollment in the public payment program; or

9.26 (v) other administrative, civil, or criminal penalties as provided by law.

9.27 (j) An applicant or license holder who acknowledges under paragraph (i) that the applicant  
9.28 or license holder elects to receive any publicly funded reimbursement from the commissioner  
9.29 for services provided under the license that are designated by the commissioner as high-risk  
9.30 under section 256B.044, subdivision 1, must provide an attestation with the notarized  
9.31 signature of the applicant or authorized agent stating whether the applicant or authorized  
9.32 agent received from an unaffiliated business or consultant any assistance preparing:

- 10.1 (1) the application;
- 10.2 (2) the renewal;
- 10.3 (3) any documentation or written policies submitted with the application;
- 10.4 (4) any documentation or written policies submitted with the renewal; or
- 10.5 (5) any documentation or written policies maintained as a requirement of licensure or
- 10.6 enrollment as a medical assistance provider.

10.7 Sec. 7. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 7, is amended  
10.8 to read:

10.9 Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that  
10.10 the program complies with all applicable rules and laws, the commissioner shall issue a  
10.11 license consistent with this section or, if applicable, a temporary change of ownership license  
10.12 under section 245A.043. At minimum, the license shall state:

- 10.13 (1) the name of the license holder;
- 10.14 (2) the address of the program;
- 10.15 (3) the effective date and expiration date of the license;
- 10.16 (4) the type of license and the specific service the license holder is licensed to provide;
- 10.17 (5) the maximum number and ages of persons that may receive services from the program;
- 10.18 and
- 10.19 (6) any special conditions of licensure.

10.20 (b) The commissioner may issue a license for a period not to exceed two years if:

- 10.21 (1) the commissioner is unable to conduct the observation required by subdivision 4,  
10.22 paragraph (a), clause (3), because the program is not yet operational;
- 10.23 (2) certain records and documents are not available because persons are not yet receiving  
10.24 services from the program; and
- 10.25 (3) the applicant complies with applicable laws and rules in all other respects.

10.26 (c) A decision by the commissioner to issue a license does not guarantee that any person  
10.27 or persons will be placed or cared for in the licensed program.

10.28 (d) Except as provided in paragraphs (i) and (j), the commissioner shall not issue a  
10.29 license if the applicant, license holder, or an affiliated controlling individual has:

11.1 (1) been disqualified and the disqualification was not set aside and no variance has been  
11.2 granted;

11.3 (2) been denied a license under this chapter or chapter 142B within the past two years;

11.4 (3) had a license issued under this chapter or chapter 142B revoked within the past five  
11.5 years; or

11.6 (4) failed to submit the information required of an applicant under subdivision 1,  
11.7 paragraph (f), (g), ~~or (h)~~, or (j), after being requested by the commissioner.

11.8 When a license issued under this chapter or chapter 142B is revoked, the license holder  
11.9 and each affiliated controlling individual with a revoked license may not hold any license  
11.10 under chapter 245A for five years following the revocation, and other licenses held by the  
11.11 applicant or license holder or licenses affiliated with each controlling individual shall also  
11.12 be revoked.

11.13 (e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license  
11.14 affiliated with a license holder or controlling individual that had a license revoked within  
11.15 the past five years if the commissioner determines that (1) the license holder or controlling  
11.16 individual is operating the program in substantial compliance with applicable laws and rules  
11.17 and (2) the program's continued operation is in the best interests of the community being  
11.18 served.

11.19 (f) Notwithstanding paragraph (d), the commissioner may issue a new license in response  
11.20 to an application that is affiliated with an applicant, license holder, or controlling individual  
11.21 that had an application denied within the past two years or a license revoked within the past  
11.22 five years if the commissioner determines that (1) the applicant or controlling individual  
11.23 has operated one or more programs in substantial compliance with applicable laws and rules  
11.24 and (2) the program's operation would be in the best interests of the community to be served.

11.25 (g) In determining whether a program's operation would be in the best interests of the  
11.26 community to be served, the commissioner shall consider factors such as the number of  
11.27 persons served, the availability of alternative services available in the surrounding  
11.28 community, the management structure of the program, whether the program provides  
11.29 culturally specific services, and other relevant factors.

11.30 (h) The commissioner shall not issue or reissue a license under this chapter if an individual  
11.31 living in the household where the services will be provided as specified under section  
11.32 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside  
11.33 and no variance has been granted.

12.1 (i) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued  
12.2 under this chapter has been suspended or revoked and the suspension or revocation is under  
12.3 appeal, the program may continue to operate pending a final order from the commissioner.  
12.4 If the license under suspension or revocation will expire before a final order is issued, a  
12.5 temporary provisional license may be issued provided any applicable license fee is paid  
12.6 before the temporary provisional license is issued.

12.7 (j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of  
12.8 a controlling individual or license holder, and the controlling individual or license holder  
12.9 is ordered under section 245C.17 to be immediately removed from direct contact with  
12.10 persons receiving services or is ordered to be under continuous, direct supervision when  
12.11 providing direct contact services, the program may continue to operate only if the program  
12.12 complies with the order and submits documentation demonstrating compliance with the  
12.13 order. If the disqualified individual fails to submit a timely request for reconsideration, or  
12.14 if the disqualification is not set aside and no variance is granted, the order to immediately  
12.15 remove the individual from direct contact or to be under continuous, direct supervision  
12.16 remains in effect pending the outcome of a hearing and final order from the commissioner.

12.17 (k) Unless otherwise specified by statute, all licenses issued under this chapter expire  
12.18 at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must  
12.19 comply with the requirements in section 245A.10 and be reissued a new license to operate  
12.20 the program or the program must not be operated after the expiration date. Adult foster care,  
12.21 family adult day services, child foster residence setting, and community residential services  
12.22 license holders must apply for and be granted a new license to operate the program or the  
12.23 program must not be operated after the expiration date. Upon implementation of the provider  
12.24 licensing and reporting hub, licenses may be issued each calendar year.

12.25 (l) The commissioner shall not issue or reissue a license under this chapter if it has been  
12.26 determined that a Tribal licensing authority has established jurisdiction to license the program  
12.27 or service.

12.28 (m) The commissioner of human services may coordinate and share data with the  
12.29 commissioner of children, youth, and families to enforce this section.

12.30 (n) For substance use disorder treatment programs, for the purposes of paragraph (a),  
12.31 clause (5), the maximum number of persons who may receive services from the program  
12.32 includes persons served at satellite locations.

13.1 Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.05, is amended to read:

13.2 **245A.05 DENIAL OF APPLICATION.**

13.3 (a) The commissioner may deny a license if an applicant or controlling individual:

13.4 (1) fails to submit a substantially complete application after receiving notice from the  
13.5 commissioner under section 245A.04, subdivision 1;

13.6 (2) fails to comply with applicable laws or rules;

13.7 (3) knowingly withholds relevant information from or gives false or misleading  
13.8 information to the commissioner in connection with an application for a license or during  
13.9 an investigation;

13.10 (4) has a disqualification that has not been set aside under section 245C.22 and no  
13.11 variance has been granted;

13.12 (5) has an individual living in the household who received a background study under  
13.13 section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that  
13.14 has not been set aside under section 245C.22, and no variance has been granted;

13.15 (6) is associated with an individual who received a background study under section  
13.16 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to  
13.17 children or vulnerable adults, and who has a disqualification that has not been set aside  
13.18 under section 245C.22, and no variance has been granted;

13.19 (7) fails to comply with section 245A.04, subdivision 1, paragraph (f) ~~or~~, (g), or (j);

13.20 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision  
13.21 6;

13.22 (9) has a history of noncompliance as a license holder or controlling individual with  
13.23 applicable laws or rules, including but not limited to this chapter and chapters 142E and  
13.24 245C;

13.25 (10) is prohibited from holding a license according to section 245.095; or

13.26 (11) is the subject of a pending administrative, civil, or criminal investigation.

13.27 (b) An applicant whose application has been denied by the commissioner must be given  
13.28 notice of the denial, which must state the reasons for the denial in plain language. Notice  
13.29 must be given by certified mail, by personal service, or through the provider licensing and  
13.30 reporting hub. The notice must state the reasons the application was denied and must inform  
13.31 the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules,

14.1 parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the  
14.2 commissioner in writing by certified mail, by personal service, or through the provider  
14.3 licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the  
14.4 commissioner within 20 calendar days after the applicant received the notice of denial. If  
14.5 an appeal request is made by personal service, it must be received by the commissioner  
14.6 within 20 calendar days after the applicant received the notice of denial. If the order is issued  
14.7 through the provider hub, the appeal must be received by the commissioner within 20  
14.8 calendar days from the date the commissioner issued the order through the hub. Section  
14.9 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

14.10 Sec. 9. Minnesota Statutes 2024, section 245D.081, subdivision 3, is amended to read:

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

14.15 (1) maintaining a current understanding of the licensing requirements sufficient to ensure  
14.16 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph  
14.17 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~  
14.18 256B.044, subdivision 7;

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

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

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

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

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

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

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

15.9 Sec. 10. Minnesota Statutes 2025 Supplement, section 256.01, subdivision 2, is amended  
15.10 to read:

15.11 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2,  
15.12 the commissioner of human services shall carry out the specific duties in paragraphs (a)  
15.13 through (z):

15.14 (a) Administer and supervise the forms of public assistance provided for by state law  
15.15 and other welfare activities or services that are vested in the commissioner. Administration  
15.16 and supervision of human services activities or services includes, but is not limited to,  
15.17 assuring timely and accurate distribution of benefits, completeness of service, and quality  
15.18 program management. In addition to administering and supervising human services activities  
15.19 vested by law in the department, the commissioner shall have the authority to:

15.20 (1) require county agency participation in training and technical assistance programs to  
15.21 promote compliance with statutes, rules, federal laws, regulations, and policies governing  
15.22 human services;

15.23 (2) monitor, on an ongoing basis, the performance of county agencies in the operation  
15.24 and administration of human services, enforce compliance with statutes, rules, federal laws,  
15.25 regulations, and policies governing welfare services and promote excellence of administration  
15.26 and program operation;

15.27 (3) develop a quality control program or other monitoring program to review county  
15.28 performance and accuracy of benefit determinations;

15.29 (4) require county agencies to make an adjustment to the public assistance benefits issued  
15.30 to any individual consistent with federal law and regulation and state law and rule and to  
15.31 issue or recover benefits as appropriate;

16.1 (5) delay or deny payment of all or part of the state and federal share of benefits and  
16.2 administrative reimbursement according to the procedures set forth in section 256.017;

16.3 (6) make contracts with and grants to public and private agencies and organizations,  
16.4 both profit and nonprofit, and individuals, using appropriated funds; and

16.5 (7) enter into contractual agreements with federally recognized Indian Tribes with a  
16.6 reservation in Minnesota to the extent necessary for the Tribe to operate a federally approved  
16.7 family assistance program or any other program under the supervision of the commissioner.  
16.8 The commissioner shall consult with the affected county or counties in the contractual  
16.9 agreement negotiations, if the county or counties wish to be included, in order to avoid the  
16.10 duplication of county and Tribal assistance program services. The commissioner may  
16.11 establish necessary accounts for the purposes of receiving and disbursing funds as necessary  
16.12 for the operation of the programs.

16.13 The commissioner shall work in conjunction with the commissioner of children, youth, and  
16.14 families to carry out the duties of this paragraph when necessary and feasible.

16.15 (b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law,  
16.16 regulation, and policy necessary to county agency administration of the programs.

16.17 (c) Administer and supervise all noninstitutional service to persons with disabilities,  
16.18 including persons who have vision impairments, and persons who are deaf, deafblind, and  
16.19 hard-of-hearing or with other disabilities. The commissioner may provide and contract for  
16.20 the care and treatment of qualified indigent children in facilities other than those located  
16.21 and available at state hospitals operated by the executive board when it is not feasible to  
16.22 provide the service in state hospitals operated by the executive board.

16.23 (d) Assist and actively cooperate with other departments, agencies and institutions, local,  
16.24 state, and federal, by performing services in conformity with the purposes of Laws 1939,  
16.25 chapter 431.

16.26 (e) Act as the agent of and cooperate with the federal government in matters of mutual  
16.27 concern relative to and in conformity with the provisions of Laws 1939, chapter 431,  
16.28 including the administration of any federal funds granted to the state to aid in the performance  
16.29 of any functions of the commissioner as specified in Laws 1939, chapter 431, and including  
16.30 the promulgation of rules making uniformly available medical care benefits to all recipients  
16.31 of public assistance, at such times as the federal government increases its participation in  
16.32 assistance expenditures for medical care to recipients of public assistance, the cost thereof  
16.33 to be borne in the same proportion as are grants of aid to said recipients.

17.1 (f) Establish and maintain any administrative units reasonably necessary for the  
17.2 performance of administrative functions common to all divisions of the department.

17.3 (g) Act as designated guardian of both the estate and the person of all the wards of the  
17.4 state of Minnesota, whether by operation of law or by an order of court, without any further  
17.5 act or proceeding whatever, except as to persons committed as developmentally disabled.

17.6 (h) Act as coordinating referral and informational center on requests for service for  
17.7 newly arrived immigrants coming to Minnesota.

17.8 (i) The specific enumeration of powers and duties as hereinabove set forth shall in no  
17.9 way be construed to be a limitation upon the general transfer of powers herein contained.

17.10 (j) Establish county, regional, or statewide schedules of maximum fees and charges  
17.11 which may be paid by county agencies for medical, dental, surgical, hospital, nursing and  
17.12 nursing home care and medicine and medical supplies under all programs of medical care  
17.13 provided by the state and for congregate living care under the income maintenance programs.

17.14 (k) Have the authority to conduct and administer experimental projects to test methods  
17.15 and procedures of administering assistance and services to recipients or potential recipients  
17.16 of public welfare. To carry out such experimental projects, it is further provided that the  
17.17 commissioner of human services is authorized to waive the enforcement of existing specific  
17.18 statutory program requirements, rules, and standards in one or more counties. The order  
17.19 establishing the waiver shall provide alternative methods and procedures of administration,  
17.20 shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and  
17.21 in no event shall the duration of a project exceed four years. It is further provided that no  
17.22 order establishing an experimental project as authorized by the provisions of this section  
17.23 shall become effective until the following conditions have been met:

17.24 (1) the United States Secretary of Health and Human Services has agreed, for the same  
17.25 project, to waive state plan requirements relative to statewide uniformity; and

17.26 (2) a comprehensive plan, including estimated project costs, shall be approved by the  
17.27 Legislative Advisory Commission and filed with the commissioner of administration.

17.28 (l) According to federal requirements and in coordination with the commissioner of  
17.29 children, youth, and families, establish procedures to be followed by local welfare boards  
17.30 in creating citizen advisory committees, including procedures for selection of committee  
17.31 members.

17.32 (m) Allocate federal fiscal disallowances or sanctions which are based on quality control  
17.33 error rates for medical assistance in the following manner:

18.1 (1) one-half of the total amount of the disallowance shall be borne by the county boards  
18.2 responsible for administering the programs. Disallowances shall be shared by each county  
18.3 board in the same proportion as that county's expenditures for the sanctioned program are  
18.4 to the total of all counties' expenditures for medical assistance. Each county shall pay its  
18.5 share of the disallowance to the state of Minnesota. When a county fails to pay the amount  
18.6 due hereunder, the commissioner may deduct the amount from reimbursement otherwise  
18.7 due the county, or the attorney general, upon the request of the commissioner, may institute  
18.8 civil action to recover the amount due; and

18.9 (2) notwithstanding the provisions of clause (1), if the disallowance results from knowing  
18.10 noncompliance by one or more counties with a specific program instruction, and that knowing  
18.11 noncompliance is a matter of official county board record, the commissioner may require  
18.12 payment or recover from the county or counties, in the manner prescribed in clause (1), an  
18.13 amount equal to the portion of the total disallowance which resulted from the noncompliance,  
18.14 and may distribute the balance of the disallowance according to clause (1).

18.15 (n) Develop and implement special projects that maximize reimbursements and result  
18.16 in the recovery of money to the state. For the purpose of recovering state money, the  
18.17 commissioner may enter into contracts with third parties. Any recoveries that result from  
18.18 projects or contracts entered into under this paragraph shall be deposited in the state treasury  
18.19 and credited to a special account until the balance in the account reaches \$1,000,000. When  
18.20 the balance in the account exceeds \$1,000,000, the excess shall be transferred and credited  
18.21 to the general fund. All money in the account is appropriated to the commissioner for the  
18.22 purposes of this paragraph.

18.23 (o) Have the authority to establish and enforce the following county reporting  
18.24 requirements:

18.25 (1) the commissioner shall establish fiscal and statistical reporting requirements necessary  
18.26 to account for the expenditure of funds allocated to counties for human services programs.  
18.27 When establishing financial and statistical reporting requirements, the commissioner shall  
18.28 evaluate all reports, in consultation with the counties, to determine if the reports can be  
18.29 simplified or the number of reports can be reduced;

18.30 (2) the county board shall submit monthly or quarterly reports to the department as  
18.31 required by the commissioner. Monthly reports are due no later than 15 working days after  
18.32 the end of the month. Quarterly reports are due no later than 30 calendar days after the end  
18.33 of the quarter, unless the commissioner determines that the deadline must be shortened to  
18.34 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss

19.1 of federal funding. Only reports that are complete, legible, and in the required format shall  
19.2 be accepted by the commissioner;

19.3 (3) if the required reports are not received by the deadlines established in clause (2), the  
19.4 commissioner may delay payments and withhold funds from the county board until the next  
19.5 reporting period. When the report is needed to account for the use of federal funds and the  
19.6 late report results in a reduction in federal funding, the commissioner shall withhold from  
19.7 the county boards with late reports an amount equal to the reduction in federal funding until  
19.8 full federal funding is received;

19.9 (4) a county board that submits reports that are late, illegible, incomplete, or not in the  
19.10 required format for two out of three consecutive reporting periods is considered  
19.11 noncompliant. When a county board is found to be noncompliant, the commissioner shall  
19.12 notify the county board of the reason the county board is considered noncompliant and  
19.13 request that the county board develop a corrective action plan stating how the county board  
19.14 plans to correct the problem. The corrective action plan must be submitted to the  
19.15 commissioner within 45 days after the date the county board received notice of  
19.16 noncompliance;

19.17 (5) the final deadline for fiscal reports or amendments to fiscal reports is one year after  
19.18 the date the report was originally due. If the commissioner does not receive a report by the  
19.19 final deadline, the county board forfeits the funding associated with the report for that  
19.20 reporting period and the county board must repay any funds associated with the report  
19.21 received for that reporting period;

19.22 (6) the commissioner may not delay payments, withhold funds, or require repayment  
19.23 under clause (3) or (5) if the county demonstrates that the commissioner failed to provide  
19.24 appropriate forms, guidelines, and technical assistance to enable the county to comply with  
19.25 the requirements. If the county board disagrees with an action taken by the commissioner  
19.26 under clause (3) or (5), the county board may appeal the action according to sections 14.57  
19.27 to 14.69; and

19.28 (7) counties subject to withholding of funds under clause (3) or forfeiture or repayment  
19.29 of funds under clause (5) shall not reduce or withhold benefits or services to clients to cover  
19.30 costs incurred due to actions taken by the commissioner under clause (3) or (5).

19.31 (p) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal  
19.32 fiscal disallowances or sanctions are based on a statewide random sample in direct proportion  
19.33 to each county's claim for that period.

20.1 (q) Be responsible for ensuring the detection, prevention, investigation, and resolution  
20.2 of fraudulent activities or behavior by applicants, recipients, and other participants in the  
20.3 human services programs administered by the department, including but not limited to a  
20.4 preenrollment risk assessment. A preenrollment risk assessment under this paragraph must  
20.5 be conducted in accordance with the procedures and criteria established in section 256B.0437.

20.6 (r) Require county agencies to identify overpayments, establish claims, and utilize all  
20.7 available and cost-beneficial methodologies to collect and recover these overpayments in  
20.8 the human services programs administered by the department.

20.9 (s) Have the authority to administer the federal drug rebate program for drugs purchased  
20.10 under the medical assistance program as allowed by section 1927 of title XIX of the Social  
20.11 Security Act and according to the terms and conditions of section 1927. Rebates shall be  
20.12 collected for all drugs that have been dispensed or administered in an outpatient setting and  
20.13 that are from manufacturers who have signed a rebate agreement with the United States  
20.14 Department of Health and Human Services.

20.15 (t) Have the authority to administer a supplemental drug rebate program for drugs  
20.16 purchased under the medical assistance program. The commissioner may enter into  
20.17 supplemental rebate contracts with pharmaceutical manufacturers and may require prior  
20.18 authorization for drugs that are from manufacturers that have not signed a supplemental  
20.19 rebate contract. Prior authorization of drugs shall be subject to the provisions of section  
20.20 256B.0625, subdivision 13.

20.21 (u) Operate the department's communication systems account established in Laws 1993,  
20.22 First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared  
20.23 communication costs necessary for the operation of the programs the commissioner  
20.24 supervises. Each account must be used to manage shared communication costs necessary  
20.25 for the operations of the programs the commissioner supervises. The commissioner may  
20.26 distribute the costs of operating and maintaining communication systems to participants in  
20.27 a manner that reflects actual usage. Costs may include acquisition, licensing, insurance,  
20.28 maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit  
20.29 organizations and state, county, and local government agencies involved in the operation  
20.30 of programs the commissioner supervises may participate in the use of the department's  
20.31 communications technology and share in the cost of operation. The commissioner may  
20.32 accept on behalf of the state any gift, bequest, devise or personal property of any kind, or  
20.33 money tendered to the state for any lawful purpose pertaining to the communication activities  
20.34 of the department. Any money received for this purpose must be deposited in the department's  
20.35 communication systems accounts. Money collected by the commissioner for the use of

21.1 communication systems must be deposited in the state communication systems account and  
21.2 is appropriated to the commissioner for purposes of this section.

21.3 (v) Receive any federal matching money that is made available through the medical  
21.4 assistance program for the consumer satisfaction survey. Any federal money received for  
21.5 the survey is appropriated to the commissioner for this purpose. The commissioner may  
21.6 expend the federal money received for the consumer satisfaction survey in either year of  
21.7 the biennium.

21.8 (w) Designate community information and referral call centers and incorporate cost  
21.9 reimbursement claims from the designated community information and referral call centers  
21.10 into the federal cost reimbursement claiming processes of the department according to  
21.11 federal law, rule, and regulations. Existing information and referral centers provided by  
21.12 Greater Twin Cities United Way or existing call centers for which Greater Twin Cities  
21.13 United Way has legal authority to represent, shall be included in these designations upon  
21.14 review by the commissioner and assurance that these services are accredited and in  
21.15 compliance with national standards. Any reimbursement is appropriated to the commissioner  
21.16 and all designated information and referral centers shall receive payments according to  
21.17 normal department schedules established by the commissioner upon final approval of  
21.18 allocation methodologies from the United States Department of Health and Human Services  
21.19 Division of Cost Allocation or other appropriate authorities.

21.20 (x) Develop recommended standards for adult foster care homes that address the  
21.21 components of specialized therapeutic services to be provided by adult foster care homes  
21.22 with those services.

21.23 (y) Authorize the method of payment to or from the department as part of the human  
21.24 services programs administered by the department. This authorization includes the receipt  
21.25 or disbursement of funds held by the department in a fiduciary capacity as part of the human  
21.26 services programs administered by the department.

21.27 (z) Designate the agencies that operate the Senior LinkAge Line under section 256.975,  
21.28 subdivision 7, and the Disability Hub under subdivision 24 as the state of Minnesota Aging  
21.29 and Disability Resource Center under United States Code, title 42, section 3001, the Older  
21.30 Americans Act Amendments of 2006, and incorporate cost reimbursement claims from the  
21.31 designated centers into the federal cost reimbursement claiming processes of the department  
21.32 according to federal law, rule, and regulations. Any reimbursement must be appropriated  
21.33 to the commissioner and treated consistent with section 256.011. All Aging and Disability  
21.34 Resource Center designated agencies shall receive payments of grant funding that supports

22.1 the activity and generates the federal financial participation according to Board on Aging  
22.2 administrative granting mechanisms.

22.3 Sec. 11. Minnesota Statutes 2024, section 256B.02, is amended by adding a subdivision  
22.4 to read:

22.5 Subd. 20. **Fraud.** "Fraud" means an intentional deception or misrepresentation made by  
22.6 a person with the knowledge that the deception could result in an unauthorized benefit to  
22.7 the person or another person. Fraud includes:

22.8 (1) the following crimes, including attempts or conspiracy to commit the crimes:

22.9 (i) theft in violation of section 609.52;

22.10 (ii) perjury in violation of section 609.48;

22.11 (iii) aggravated forgery and forgery in violation of sections 609.625 and 609.63;

22.12 (iv) medical assistance fraud in violation of section 609.466;

22.13 (v) financial transaction card fraud in violation of section 609.821;

22.14 (vi) wrongfully obtaining assistance in violation of section 256.98;

22.15 (vii) illegal remunerations in violation of section 609.542; and

22.16 (viii) a felony listed in United States Code, title 42, section 1320a-7b(b)(1) or (2), subject  
22.17 to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section  
22.18 952;

22.19 (2) any act that constitutes fraud under applicable federal or state law, including but not  
22.20 limited to knowingly and willfully submitting an application for provider status that is false  
22.21 or fraudulent in whole or in part; and

22.22 (3) an intentional submission of a claim for reimbursement under chapter 256B, knowing  
22.23 or having reason to know the claim is ineligible for reimbursement in whole or in part and  
22.24 acting with the intent to defraud the payor.

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

22.27 Subd. 21. **Provider enrollment.** ~~(a)~~ The commissioner shall enroll providers and conduct  
22.28 screening activities as required by sections 256B.0437 to 256B.0445 and Code of Federal  
22.29 Regulations, title 42, section 455, subpart E.

23.1 ~~A provider must enroll each provider-controlled location where direct services are~~  
23.2 ~~provided. The commissioner may deny a provider's incomplete application if a provider~~  
23.3 ~~fails to respond to the commissioner's request for additional information within 60 days of~~  
23.4 ~~the request. The commissioner must conduct a background study under chapter 245C,~~  
23.5 ~~including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses~~  
23.6 ~~(1) to (5), for a provider described in this paragraph. The background study requirement~~  
23.7 ~~may be satisfied if the commissioner conducted a fingerprint-based background study on~~  
23.8 ~~the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph~~  
23.9 ~~(a), clauses (1) to (5).~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24.27 ~~(h) The commissioner may revoke the enrollment of an ordering or rendering provider~~  
24.28 ~~for a period of not more than one year, if the provider fails to maintain and, upon request~~  
24.29 ~~from the commissioner, provide access to documentation relating to written orders or requests~~  
24.30 ~~for payment for durable medical equipment, certifications for home health services, or~~  
24.31 ~~referrals for other items or services written or ordered by such provider, when the~~  
24.32 ~~commissioner has identified a pattern of a lack of documentation. A pattern means a failure~~  
24.33 ~~to maintain documentation or provide access to documentation on more than one occasion.~~

25.1 ~~Nothing in this paragraph limits the authority of the commissioner to sanction a provider~~  
25.2 ~~under the provisions of section 256B.064.~~

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

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

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

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

25.13 ~~(j) As a condition of enrollment in medical assistance, the commissioner shall require~~  
25.14 ~~that a provider designated "moderate" or "high-risk" by the Centers for Medicare and~~  
25.15 ~~Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid~~  
25.16 ~~Services, its agents, or its designated contractors and the state agency, its agents, or its~~  
25.17 ~~designated contractors to conduct unannounced on-site inspections of any provider location.~~  
25.18 ~~The commissioner shall publish in the Minnesota Health Care Program Provider Manual a~~  
25.19 ~~list of provider types designated "limited," "moderate," or "high-risk," based on the criteria~~  
25.20 ~~and standards used to designate Medicare providers in Code of Federal Regulations, title~~  
25.21 ~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.~~  
25.22 ~~The commissioner's designations are not subject to administrative appeal.~~

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

25.29 ~~(l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable~~  
25.30 ~~medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers~~  
25.31 ~~meeting the durable medical equipment provider and supplier definition in clause (3),~~  
25.32 ~~operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is~~  
25.33 ~~annually renewed and designates the Minnesota Department of Human Services as the~~  
25.34 ~~obligee, and must be submitted in a form approved by the commissioner. For purposes of~~

26.1 ~~this clause, the following medical suppliers are not required to obtain a surety bond: a~~  
26.2 ~~federally qualified health center, a home health agency, the Indian Health Service, a~~  
26.3 ~~pharmacy, and a rural health clinic.~~

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

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

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

26.30 **Sec. 13. [256B.0437] PREENROLLMENT ASSESSMENT.**

26.31 (a) Before enrolling a provider or agency, the commissioner may complete a  
26.32 preenrollment risk assessment of the provider or agency seeking to enroll to confirm the  
26.33 provider or agency's eligibility and the provider or agency's ability to meet the requirements  
26.34 of this chapter. The commissioner must utilize a risk-score framework as a component of

27.1 the assessment that identifies service-specific fraud risk indicators, including but not limited  
27.2 to organizational readiness, financial stability, compliance history, and addressing service  
27.3 necessity.

27.4 (b) Based on the assessment of fraud risk indicators described in paragraph (a), the  
27.5 commissioner may deem the applicant ineligible and deny or rescind enrollment. The  
27.6 decision to deny or rescind enrollment must be made in writing and sent using a  
27.7 signature-verified confirmed delivery method. An applicant may request reconsideration  
27.8 of the decision regarding the applicant's eligibility in writing within 30 business days after  
27.9 the date the notice was issued. The commissioner must notify each applicant of the  
27.10 commissioner's final decision regarding the applicant's eligibility.

27.11 (c) A provider enrolled before July 1, 2026, that billed for services on or after January  
27.12 1, 2025, must receive a positive preenrollment risk assessment no later than July 1, 2027,  
27.13 to remain eligible. A provider or agency enrolled before July 1, 2026, that has not billed  
27.14 for services on or after January 1, 2025, must receive a positive preenrollment risk assessment  
27.15 no later than July 1, 2026, to remain eligible. A provider that becomes ineligible under this  
27.16 paragraph regains eligibility after receiving a positive assessment under this section if the  
27.17 provider remains otherwise eligible.

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

27.19 **Sec. 14. [256B.044] PROVIDER ENROLLMENT.**

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

27.25 (b) The list and criteria are not subject to the requirements of chapter 14, and section  
27.26 14.386 does not apply.

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

27.28 **Subd. 2. Service location enrollment.** A provider must enroll each provider-controlled  
27.29 location where direct services are provided.

27.30 **Subd. 3. Incomplete provider enrollment applications.** The commissioner may deny  
27.31 a provider's incomplete enrollment application if a provider fails to respond to the  
27.32 commissioner's request for additional information within 60 days of the request.

28.1 Subd. 4. **Required background studies.** (a) The commissioner must conduct a  
28.2 background study under chapter 245C, including a review of databases in section 245C.08,  
28.3 subdivision 1, paragraph (a), clauses (1) to (5), for a provider applying for enrollment under  
28.4 section 256B.04, subdivision 21. The background study requirement may be satisfied if the  
28.5 commissioner conducted a fingerprint-based background study on the provider that included  
28.6 a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

28.7 (b) As a condition of enrollment in medical assistance, the commissioner must require  
28.8 that a high-risk provider, or a person with a direct or indirect ownership interest in the  
28.9 provider of five percent or higher, consent to criminal background checks, including  
28.10 fingerprinting, when required to do so under state law or by a determination by the  
28.11 commissioner or the Centers for Medicare and Medicaid Services (CMS) that a provider is  
28.12 designated high-risk.

28.13 Subd. 5. **Surety bonds.** (a) The commissioner may require a provider to purchase a  
28.14 surety bond as a condition of initial enrollment, revalidation, reenrollment, reinstatement,  
28.15 or continued enrollment if:

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

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

28.19 (3) the provider or category of providers is designated high-risk pursuant to subdivision  
28.20 1 and Code of Federal Regulations, title 42, section 455.450.

28.21 (b) The surety bond must be in an amount of \$100,000 or ten percent of the provider's  
28.22 payments from Medicaid during the immediately preceding 12 months, whichever is greater.  
28.23 The surety bond must name the Department of Human Services as an obligee, must be  
28.24 purchased new annually, and must allow for recovery of costs and fees in pursuing a claim  
28.25 on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must  
28.26 occur within six years from the date the debt is affirmed by a final agency decision. An  
28.27 agency decision is final when the right to appeal the debt has been exhausted or the time to  
28.28 appeal has expired under section 256B.064.

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

28.31 Subd. 6. **Required on-site inspections.** (a) As a condition of enrollment in medical  
28.32 assistance, the commissioner shall require that a provider designated moderate-risk or  
28.33 high-risk by CMS or the commissioner permit CMS, CMS's agents, or CMS's designated

29.1 contractors and the state agency, the state agency's agents, or the state agency's designated  
29.2 contractors to conduct unannounced on-site inspections of any provider location.

29.3 (b) Consistent with the commissioner's authority under Code of Federal Regulations,  
29.4 title 42, section 455.452, prior to enrolling, prior to re-enrolling, and prior to revalidating  
29.5 a provider designated moderate-risk or high-risk, the commissioner must conduct  
29.6 unannounced on-site inspections of all provider locations.

29.7 Subd. 7. **Compliance programs.** (a) The commissioner may require, as a condition of  
29.8 enrollment in medical assistance, that a provider within a particular industry sector or  
29.9 category establish a compliance program that contains the core elements established by  
29.10 CMS.

29.11 (b) If an enrolled provider is required by the commissioner or by law to designate an  
29.12 individual as the provider's compliance officer, the compliance officer must:

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

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

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

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

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

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

29.26 Subd. 8. **Correspondence and notification.** The commissioner may deliver  
29.27 correspondence and notifications, including notifications of termination and other actions,  
29.28 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to  
29.29 correspondence and notifications related to background studies.

29.30 Sec. 15. **[256B.0441] PROVIDER REVALIDATION.**

29.31 Subdivision 1. **Provider revalidation schedule.** The commissioner shall revalidate:

- 30.1 (1) each provider at least once every five years;  
30.2 (2) each personal care assistance agency, community first services and supports (CFSS)  
30.3 agency-provider, and CFSS financial management services provider at least once every  
30.4 three years;  
30.5 (3) each early intensive developmental and behavioral intervention agency at least once  
30.6 every three years; and  
30.7 (4) at the commissioner's discretion, any medical-assistance-only provider type the  
30.8 commissioner deems high-risk under section 256B.044, subdivision 1.

30.9 Subd. 2. **Revalidation procedures.** The commissioner shall conduct revalidation as  
30.10 follows:

- 30.11 (1) provide 30 days' notice of the revalidation due date including instructions for  
30.12 revalidation and a list of materials the provider must submit; and  
30.13 (2) if a provider fails to respond or remedy a deficiency within the 30-day time period,  
30.14 give 30 days' notice of termination and immediately suspend the provider's ability to bill.  
30.15 The provider does not have the right to appeal suspension of ability to bill.

30.16 Sec. 16. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**  
30.17 **TERMINATIONS.**

30.18 Subdivision 1. **Commissioner's general authority to suspend individual provider's**  
30.19 **enrollment.** (a) If a provider fails to comply with any individual provider requirement or  
30.20 condition of participation, the commissioner may suspend the provider's ability to bill until  
30.21 the provider comes into compliance.

30.22 (b) The commissioner's decision to suspend the provider is not subject to an administrative  
30.23 appeal.

30.24 Subd. 2. **Commissioner's authority to revoke enrollment of certain providers for**  
30.25 **lack of documentation.** (a) The commissioner may revoke the enrollment of an ordering  
30.26 or rendering provider for a period of not more than one year, if the provider fails to maintain  
30.27 and, upon request from the commissioner, provide access to documentation relating to  
30.28 written orders or requests for payment for durable medical equipment, certifications for  
30.29 home health services, or referrals for other items or services written or ordered by the  
30.30 provider, when the commissioner has identified a pattern of a lack of documentation. A  
30.31 pattern means a failure to maintain documentation or provide access to documentation on  
30.32 more than one occasion.

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

31.3 Subd. 3. Commissioner's duty to terminate provider enrollment. (a) Except as  
31.4 provided in paragraph (b), the commissioner must terminate or deny the enrollment of any  
31.5 individual or entity if the individual or entity has been terminated from participation in  
31.6 Medicare or under the Medicaid program or Children's Health Insurance Program of any  
31.7 other state.

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

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

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

31.14 (3) serves primarily a pediatric population.

31.15 Subd. 4. Commissioner's authority to terminate provider enrollment for lack of  
31.16 submitted claims. The commissioner may terminate the enrollment of an individual or  
31.17 entity provider if the individual or entity provider has not submitted any claims in the  
31.18 previous 12 consecutive calendar months.

31.19 Sec. 17. [256B.0443] PROVIDER PAYMENT WITHHOLDS.

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

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

31.26 Sec. 18. [256B.0444] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS  
31.27 FOR HIGH-RISK PROVIDERS.

31.28 Subdivision 1. Applicability. This section applies to any agency that provides a service  
31.29 designated by the commissioner as high-risk under section 256B.044, subdivision 1. For  
31.30 purposes of this section, "agency" means the legal entity that is applying to be or is enrolled

32.1 with Minnesota health care programs as a medical assistance provider according to Minnesota  
32.2 Rules, part 9505.0195.

32.3 Subd. 2. **Mandatory training compliance.** (a) Effective January 1, 2027, before applying  
32.4 for enrollment or reenrollment as a medical assistance provider, an agency applying to  
32.5 provide services designated by the commissioner as high-risk must require all owners of  
32.6 the agency who are active in the day-to-day management and operations of the agency and  
32.7 managerial and supervisory employees to complete compliance training. All individuals  
32.8 who must complete training under this subdivision must repeat the training prior to  
32.9 revalidation of the agency as a medical assistance provider.

32.10 (b) New owners active in day-to-day management and operations of the agency and new  
32.11 managerial and supervisory employees of the agency must complete compliance training  
32.12 under this subdivision within 30 calendar days of becoming an owner of or employed by  
32.13 the agency and prior to conducting any management and operations activities for the agency.  
32.14 If an individual moves to another agency providing the same service and serves in a similar  
32.15 ownership or employment capacity, the individual is not required to repeat the training  
32.16 required under this subdivision. If the individual chooses not to repeat the compliance  
32.17 training, the individual must provide the agency with documentation proving the individual  
32.18 completed the compliance training within the provider revalidation schedule for the relevant  
32.19 provider type as determined by the commissioner under section 256B.0441.

32.20 (c) The commissioner must determine the format and content of the compliance training.  
32.21 The training must include the following topics, adapted as necessary for each provider type  
32.22 subject to the requirements of this subdivision:

32.23 (1) state and federal program billing, documentation, and service delivery requirements;

32.24 (2) enrollment requirements;

32.25 (3) provider program integrity, including fraud prevention, detection, and penalties;

32.26 (4) fair labor standards;

32.27 (5) workplace safety requirements; and

32.28 (6) recent changes in service requirements.

32.29 Sec. 19. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**  
32.30 **FOR SPECIFIC PROVIDER TYPES.**

32.31 Subdivision 1. **Durable medical equipment provider or supplier.** (a) For purposes of  
32.32 this subdivision, "durable medical equipment provider or supplier" means a medical supplier

33.1 that can purchase medical equipment or supplies for sale or rent to the general public and  
33.2 is able to perform or arrange for necessary repairs to and maintenance of equipment offered  
33.3 for sale or rent.

33.4 (b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable  
33.5 medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable  
33.6 medical equipment provider or supplier definition in paragraph (a), operating in Minnesota,  
33.7 and receiving Medicaid money must purchase a surety bond that is annually renewed,  
33.8 designates the Department of Human Services as the obligee, and is submitted in a form  
33.9 approved by the commissioner. For purposes of this paragraph, the following medical  
33.10 suppliers are not required to obtain a surety bond: a federally qualified health center, a home  
33.11 health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

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

33.23 Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled  
33.24 provider that is also licensed by the commissioner under chapter 245A must designate an  
33.25 individual as the licensee's compliance officer under section 256B.044, subdivision 7,  
33.26 paragraph (b).

33.27 Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that  
33.28 is also licensed by the commissioner of health as a home care provider under chapter 144A  
33.29 with a home and community-based services designation under section 144A.484 on the  
33.30 home care license, or as an assisted living facility under chapter 144G, must designate an  
33.31 individual as the licensee's compliance officer under section 256B.044, subdivision 7,  
33.32 paragraph (b).

34.1 **Sec. 20. [256B.0447] PREPAYMENT REVIEW.**

34.2 **Subdivision 1. Prepayment review.** The commissioner must conduct prepayment review  
34.3 of all submitted fee-for-service medical assistance claims to ensure compliance with state  
34.4 and federal law and prevent improper payments before payment.

34.5 **Subd. 2. Notice.** (a) Except as provided in paragraph (b), the commissioner must provide  
34.6 written notice to a provider placed under prepayment review at least 60 days before the  
34.7 review is implemented. The notice must include:

34.8 (1) the basis for the review; and

34.9 (2) the effective date of the review.

34.10 **(b) The commissioner may delay, limit, or withhold notice to a provider if providing**  
34.11 **notice would compromise program integrity, prejudice an audit or investigation, or conflict**  
34.12 **with federal law or federal guidance.**

34.13 **Subd. 3. Continued enrollment of new clients.** Nothing in this section prohibits an  
34.14 enrolled provider that is subject to prepayment review from enrolling new clients or  
34.15 beneficiaries during the period of review unless otherwise prohibited by law or by a separate  
34.16 action of the commissioner.

34.17 **Subd. 4. Timely claims processing.** The commissioner must conduct prepayment review  
34.18 in a manner consistent with Code of Federal Regulations, title 42, section 447.45.

34.19 **Subd. 5. Relationship to other actions.** Prepayment review under this section does not  
34.20 preclude the commissioner from conducting a preliminary investigation, full investigation,  
34.21 payment suspension, postpayment review, audit, overpayment recovery, sanction, or referral  
34.22 to law enforcement under this chapter or under applicable federal law.

34.23 **Subd. 6. Phase-in.** The commissioner must develop a process to phase in the prepayment  
34.24 review process under this section based on provider volume, with high-volume providers  
34.25 subject to prepayment review first.

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

34.27 **Sec. 21. [256B.0448] POSTPAYMENT REVIEW.**

34.28 **Subdivision 1. Purpose and authority.** The commissioner may conduct postpayment  
34.29 review of claims, encounters, cost reports, rate submissions, and other billings submitted  
34.30 for payment or reimbursement under this chapter to identify improper payments and recover  
34.31 payments made in violation of state or federal law or program requirements.

35.1 Subd. 2. **Scope of review.** The commissioner may conduct postpayment review on a  
35.2 claim-by-claim basis or through other review methods authorized by state or federal law.

35.3 Subd. 3. **Provider obligations.** (a) A provider subject to postpayment review must  
35.4 maintain documentation necessary to support claims, encounters, cost reports, rate  
35.5 submissions, other billings submitted for payment or reimbursement under this chapter, and  
35.6 compliance with program requirements.

35.7 (b) The commissioner may require a provider to submit records or supporting  
35.8 documentation relevant to a postpayment review.

35.9 (c) A provider's failure to provide requested records or supporting documentation to the  
35.10 commissioner according to the timeline specified by the commissioner may result in recovery  
35.11 of payments or sanctions under section 256B.064 and other applicable laws.

35.12 Subd. 4. **Recovery and sanctions.** If postpayment review identifies an overpayment or  
35.13 other noncompliance with medical assistance payment requirements, the commissioner may  
35.14 recover payments and impose sanctions in accordance with section 256B.064 and other  
35.15 applicable laws.

35.16 Subd. 5. **Relationship to other actions.** Conducting postpayment review of a provider  
35.17 under this section does not preclude the commissioner from conducting a preliminary  
35.18 investigation, full investigation, enhanced prepayment review, payment suspension, audit,  
35.19 overpayment recovery, sanction, or referral to law enforcement under this chapter or  
35.20 applicable federal law.

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

35.22 Sec. 22. **[256B.0639] ACCESS TO RECORDS AND SERVICE LOCATIONS.**

35.23 (a) The commissioner may conduct on-site inspections of any and all vendors of medical  
35.24 care and the vendor's service locations. The vendor must give the commissioner immediate  
35.25 access without prior notice to the vendor's offices and service locations during regular  
35.26 business hours. The commissioner may request records and documents during an on-site  
35.27 inspection or by making a written request to the vendor. The commissioner may use the  
35.28 records and documents to verify the accuracy of any information submitted by the vendor  
35.29 to the commissioner, to determine compliance with service delivery and billing requirements,  
35.30 or to determine compliance with any other applicable laws or rules. Failing to provide the  
35.31 commissioner with immediate access to records or documents or failing to comply with a  
35.32 written request for records or documents, is a refusal under section 256B.064, subdivision

36.1 1a, paragraph (a), clause (5), and is cause for the vendor's immediate suspension of payment  
36.2 and termination under section 256B.064.

36.3 (b) Section 256B.27, subdivisions 4 and 5, apply to actions taken by the commissioner  
36.4 under this section. Notwithstanding any other law to the contrary, a vendor of medical care  
36.5 shall not be subject to any civil or criminal liability for providing access to medical records  
36.6 to the commissioner of human services pursuant to this section.

36.7 Sec. 23. Minnesota Statutes 2025 Supplement, section 256B.064, subdivision 1a, is  
36.8 amended to read:

36.9 Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against  
36.10 any individual or entity that receives payments from medical assistance or provides goods  
36.11 or services for which payment is made from medical assistance for any of the following:

36.12 (1) fraud, theft, or abuse in connection with the provision of goods and services to  
36.13 recipients of public assistance for which payment is made from medical assistance;

36.14 (2) a pattern of presentment of false or duplicate claims or claims for services not  
36.15 medically necessary;

36.16 (3) a pattern of making false statements of material facts for the purpose of obtaining  
36.17 greater compensation than that to which the individual or entity is legally entitled;

36.18 (4) suspension or termination as a Medicare vendor;

36.19 (5) refusal to grant the state agency access during regular business hours to examine all  
36.20 records necessary to disclose the extent of services provided to program recipients and  
36.21 appropriateness of claims for payment;

36.22 (6) failure to repay an overpayment provided in section 256B.0641 or a fine finally  
36.23 established under this section;

36.24 (7) failure to correct errors in the maintenance of health service or financial records for  
36.25 which a fine was imposed or after issuance of a warning by the commissioner; and

36.26 (8) any reason for which an individual or entity could be excluded from participation in  
36.27 the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

36.28 (b) For the purposes of this section, goods or services for which payment is made from  
36.29 medical assistance includes but is not limited to care and services identified in section  
36.30 256B.0625 or provided pursuant to any federally approved waiver.

37.1 (c) Regardless of the source of payment or other item of value, the commissioner may  
37.2 impose sanctions against any individual or entity that solicits, receives, pays, or offers to  
37.3 pay any illegal remuneration as described in section 142E.51, subdivision 6a, in violation  
37.4 of section 609.542, subdivision 2, or in violation of United States Code, title 42, section  
37.5 1320a-7b(b)(1) or (2). No conviction is required before the commissioner can impose  
37.6 sanctions under this paragraph.

37.7 (d) The commissioner may impose sanctions against a pharmacy provider for failure to  
37.8 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph  
37.9 (g).

37.10 (e) The commissioner may impose sanctions against a pharmacy provider for failure to  
37.11 respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision  
37.12 13e, paragraph (i).

37.13 (f) For purposes of this subdivision, "abuse" does not include billing errors that result  
37.14 in unintended overcharges.

37.15 Sec. 24. Minnesota Statutes 2024, section 256B.064, subdivision 1b, is amended to read:

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

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

37.21 (2) temporarily withholding payments to an individual or entity;

37.22 (3) suspending participation in the program;

37.23 (4) terminating participation in the program; or

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

37.25 (b) When imposing sanctions under this section, the commissioner ~~shall~~ must consider  
37.26 the nature, chronicity, or severity of the conduct and the effect of the conduct on the health  
37.27 and safety of persons served by the individual or entity.

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

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

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

38.4 Sec. 25. Minnesota Statutes 2024, section 256B.064, subdivision 1c, is amended to read:

38.5 Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner  
38.6 may obtain monetary recovery from an individual or entity ~~that has been improperly paid~~  
38.7 ~~by the department either as a result of conduct described in subdivision 1a or as a result of~~  
38.8 ~~an error by the individual or entity submitting the claim or by the department, regardless of~~  
38.9 ~~whether the error was intentional. Patterns need not be proven as a precondition to monetary~~  
38.10 ~~recovery of erroneous or false claims, duplicate claims, claims for services not medically~~  
38.11 ~~necessary, or claims based on false statements~~ for an overpayment as defined in Code of  
38.12 Federal Regulations, title 42, section 433.304.

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

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

38.21 Sec. 26. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

38.22 Subd. 1d. **Investigative costs.** (a) The commissioner may seek recovery of investigative  
38.23 costs from any individual or entity that ~~willfully submits a claim for reimbursement for~~  
38.24 ~~services that the individual or entity knows, or reasonably should have known, is a false~~  
38.25 ~~representation and that results in the payment of public funds for which the individual or~~  
38.26 ~~entity is ineligible~~ violates the False Claims Act pursuant to United States Code, title 31,  
38.27 section 3729-3733 or section 15C.02.

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

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

39.1 Sec. 27. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

39.2 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The  
39.3 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions  
39.4 to be imposed upon an individual or entity under this section. Except as provided in  
39.5 ~~paragraphs (b) and (d), neither subdivision 2c, the commissioner must not obtain~~ a monetary  
39.6 recovery ~~nor~~ or impose a sanction ~~will be imposed by the commissioner~~ without prior notice  
39.7 and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed  
39.8 action, provided that the commissioner may suspend or reduce payment to an individual or  
39.9 entity, except a nursing home or convalescent care facility, after notice and prior to the  
39.10 hearing if in the commissioner's opinion that action is necessary to protect the public welfare  
39.11 and the interests of the program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40.26 ~~(f) (b) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction~~  
40.27 ~~is to be imposed, an individual or entity may request a contested case, as defined in section~~  
40.28 ~~14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal~~  
40.29 ~~request must be received by the commissioner no later than 30 days after the date the~~  
40.30 ~~notification of monetary recovery or sanction was mailed to the individual or entity. The~~  
40.31 ~~appeal request must specify:~~

40.32 ~~(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount~~  
40.33 ~~involved for each disputed item;~~

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

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

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

41.6 (5) other information required by the commissioner.

41.7 ~~(g) The commissioner may order an individual or entity to forfeit a fine for failure to~~  
41.8 ~~fully document services according to standards in this chapter and Minnesota Rules, chapter~~  
41.9 ~~9505. The commissioner may assess fines if specific required components of documentation~~  
41.10 ~~are missing. The fine for incomplete documentation shall equal 20 percent of the amount~~  
41.11 ~~paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000,~~  
41.12 ~~whichever is less. If the commissioner determines that an individual or entity repeatedly~~  
41.13 ~~violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to~~  
41.14 ~~the provision of services to program recipients and the submission of claims for payment,~~  
41.15 ~~the commissioner may order an individual or entity to forfeit a fine based on the nature,~~  
41.16 ~~severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the~~  
41.17 ~~value of the claims, whichever is greater.~~

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

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

41.23 Sec. 28. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision  
41.24 to read:

41.25 Subd. 2a. **Imposition of fines.** (a) The commissioner may order an individual or entity  
41.26 to forfeit a fine for failure to fully document services according to standards in this chapter  
41.27 and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required  
41.28 components of documentation are missing. The fine for incomplete documentation equals  
41.29 20 percent of the amount paid on the claims for reimbursement submitted by the individual  
41.30 or entity, or up to \$5,000, whichever is less.

41.31 (b) If the commissioner determines that an individual or entity repeatedly violated this  
41.32 chapter, chapter 245G or 254B, or Minnesota Rules, chapter 9505, related to the provision  
41.33 of services to program recipients and the submission of claims for payment, the commissioner

42.1 may order an individual or entity to forfeit a fine based on the nature, severity, and chronicity  
42.2 of the violations, in an amount of up to \$5,000 or 20 percent of the value of the claims,  
42.3 whichever is greater.

42.4 (c) The individual or entity must pay the fine assessed on or before the payment date  
42.5 specified by the commissioner. If the individual or entity fails to pay the fine, the  
42.6 commissioner may withhold or reduce payments and recover the amount of the fine.

42.7 (d) A timely appeal stays payment of the fine until the commissioner issues a final order.

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

42.9 Sec. 29. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision  
42.10 to read:

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

42.16 (b) Within five days of taking an action under paragraph (a), the commissioner must  
42.17 send notice of the suspension or termination. The notice must:

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

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

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

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

42.24 Sec. 30. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision  
42.25 to read:

42.26 Subd. 2c. **Imposition of withholding or reduction of payments without prior**  
42.27 **notice.** (a) Except when the commissioner finds good cause not to suspend payments under  
42.28 Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner must  
42.29 temporarily withhold or reduce payments to an individual or entity without providing advance  
42.30 notice of the withholding or reduction if either of the following occurs:

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

43.3 (2) the commissioner determines there is a credible allegation of fraud for which an  
43.4 investigation is pending under the program. Allegations are considered credible when the  
43.5 allegations have indicia of reliability and the commissioner has reviewed all allegations,  
43.6 facts, and evidence carefully and acts judiciously on a case-by-case basis.

43.7 (b) A credible allegation of fraud is an allegation that has been verified by the state from  
43.8 any source, including but not limited to:

43.9 (1) fraud hotline complaints;

43.10 (2) complaints from service recipients, guardians of service recipients, and case managers  
43.11 of service recipients;

43.12 (3) claims data mining;

43.13 (4) patterns identified through provider audits, civil false claims cases, law enforcement  
43.14 investigations, and investigations by other state or federal agencies; and

43.15 (5) court filings or other legal documents.

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

43.19 (1) state that payments are being withheld or reduced according to paragraph (a);

43.20 (2) set forth the allegations as to the nature of the withholding or reduction in a manner  
43.21 reasonably calculated to provide notice, which must include but is not limited to date ranges  
43.22 of suspected claims, locations of suspected service delivery, general nature of individual or  
43.23 entity conduct, but need not disclose specific information that the commissioner determines  
43.24 is likely to jeopardize an ongoing investigation;

43.25 (3) except in the case of a conviction for conduct described in subdivision 1a, state that  
43.26 the withholding or reduction is for a temporary period and cite the circumstances under  
43.27 which withholding will be terminated;

43.28 (4) identify the types of claims to which the withholding or reduction applies; and

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

44.1 (d) The commissioner must immediately cease to withhold or reduce payments under  
44.2 this subdivision and must release the withheld or reduced payments no later than ten days  
44.3 following the earlier of (1) the individual or entity posts a surety bond as provided under  
44.4 subdivision 2e, (2) the commissioner determines there is insufficient evidence of fraud by  
44.5 the individual or entity, or (3) legal proceedings relating to the alleged fraud are completed,  
44.6 unless the commissioner has sent notice of intention to impose monetary recovery or  
44.7 sanctions.

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

44.9 Sec. 31. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision  
44.10 to read:

44.11 Subd. 2d. **Appeal of temporary payment withhold.** (a) Upon receipt of a notice under  
44.12 subdivision 2c, paragraph (c), that a payment withhold is imposed, an individual or entity  
44.13 may request a review under paragraph (c) of this subdivision by filing with the commissioner  
44.14 a written request of appeal. The appeal request must be received by the commissioner no  
44.15 later than 30 days after the date the notification of the payment withhold was mailed to the  
44.16 individual or entity. The appeal request must specify the reason the payment withholding  
44.17 decision is in error and clearly request a hearing. The commissioner must refer the appeal  
44.18 request to the Court of Administrative Hearings within ten business days of receiving the  
44.19 appeal request.

44.20 (b) The cost of the review under paragraph (c) must be paid by the individual or entity.

44.21 (c) The burden of proof upon appeal of a temporary withhold is limited to whether the  
44.22 commissioner can establish there is a credible allegation of fraud as provided in subdivision  
44.23 2c, paragraph (a), clause (2). The administrative law judge's recommendation to the  
44.24 commissioner must not make findings on the veracity of the underlying allegations of fraud,  
44.25 as the underlying investigation remains ongoing and underlying facts may be litigated in  
44.26 future administrative, civil, or criminal proceedings when a final agency decision is issued.

44.27 (d) To protect the integrity of the ongoing investigation, the commissioner must submit  
44.28 evidence to support the action to the administrative law judge under seal. The individual or  
44.29 entity may submit evidence to the administrative law judge that supports the position of the  
44.30 individual or entity that the payment withholding decision is in error. The administrative  
44.31 law judge must review the evidence in camera. The commissioner shall not be subject to  
44.32 discovery by the individual or entity during the proceedings.

45.1 (e) The commissioner must provide notice to the individual or entity when the  
45.2 administrative law judge makes a recommendation. The notice must be sent within ten  
45.3 business days of the administrative law judge's completed recommendation and must state  
45.4 that the appeal process under this subdivision is completed.

45.5 (f) The administrative law judge's findings of facts, conclusions of law, and  
45.6 recommendation as to whether there is a credible allegation of fraud, may not be used or  
45.7 considered for any other purpose, including impeachment, in any civil, criminal,  
45.8 administrative, or contractual proceeding. The administrative law judge's findings of facts,  
45.9 conclusions of law, and recommendation may not be held conclusive or binding or used as  
45.10 evidence in any separate or subsequent action in any other forum, be it contractual,  
45.11 administrative, or judicial, regardless of whether the action involves the same or related  
45.12 parties or involves the same facts.

45.13 Sec. 32. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision  
45.14 to read:

45.15 Subd. 2e. **Release of withheld or reduced payments.** (a) The commissioner must release  
45.16 to the individual or entity subject to a withhold or reduction of payments under subdivision  
45.17 2c the amount of withheld or reduced payments for previously rendered services if the  
45.18 individual or entity posts a surety bond in an amount equal to the greater of (1) the amount  
45.19 of the withheld or reduced payments, or (2) the amount of the risk of exposure identified  
45.20 by the commissioner. A surety bond posted under this subdivision must be in addition to  
45.21 any other surety bond the individual or entity may have previously purchased as a condition  
45.22 of enrollment as a medical assistance provider.

45.23 (b) The commissioner may require an individual or owners or employees of an entity  
45.24 that posts a surety bond under this subdivision to complete remedial provider compliance  
45.25 training. The commissioner may require an individual or owners or employees of an entity  
45.26 that posts a surety bond under this subdivision to engage a third party approved by the  
45.27 commissioner to temporarily manage or provide technical assistance to the individual or  
45.28 entity.

45.29 (c) If the individual or entity elects to post a surety bond under this subdivision, the  
45.30 commissioner is not prohibited from utilizing prepayment review of submitted claims for  
45.31 ongoing services rendered by the individual or entity, imposing sanctions on the individual  
45.32 or entity, seeking recovery for improper payments paid to the individual or entity, or  
45.33 exercising any other regulatory powers, including enforcement of medical assistance provider  
45.34 enrollment requirements, licensing standards, or service standards.

46.1 Sec. 33. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision  
46.2 to read:

46.3 Subd. 2f. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction  
46.4 for a crime related to the provision, management, or administration of a health service under  
46.5 medical assistance, a payment held pursuant to this section by the commissioner or a managed  
46.6 care organization that contracts with the commissioner under section 256B.035 is forfeited  
46.7 to the commissioner or managed care organization, regardless of the amount charged in the  
46.8 criminal complaint or the amount of criminal restitution ordered.

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

46.10 Sec. 34. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

46.11 Subd. 3. **Mandates on prohibited payments.** (a) The commissioner ~~shall~~ must maintain  
46.12 and publish a list of each excluded individual and entity that was convicted of a crime related  
46.13 to the provision, management, or administration of a medical assistance health service, or  
46.14 suspended or terminated under ~~subdivision 2~~ this section. Medical assistance payments  
46.15 cannot be made by an individual or entity for items or services furnished either directly or  
46.16 indirectly by an excluded individual or entity, or at the direction of excluded individuals or  
46.17 entities.

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

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

46.26 (d) An entity that pays medical assistance program funds to an individual or entity on  
46.27 the exclusion list must refund any payment related to ~~either~~ and items ~~or~~ and services rendered  
46.28 by an individual or entity on the exclusion list from the date the individual or entity is first  
46.29 paid or the date the individual or entity is placed on the exclusion list, whichever is later,  
46.30 and an entity may be subject to:

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

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

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

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

47.6 Sec. 35. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

47.7 Subd. 4. **Notice.** (a) The department ~~shall~~ must serve the notice required under ~~subdivision~~  
47.8 2 this section using a signature-verified confirmed delivery method to the address submitted  
47.9 to the department by the individual or entity. Service is complete upon mailing.

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

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

47.17 Sec. 36. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

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

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

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

47.28 (d) After an investigation is complete, the reporter's name must be kept confidential.  
47.29 The subject of the report may compel disclosure of the reporter's name only with the consent  
47.30 of the reporter or upon a written finding by a district court that the report was false and there  
47.31 is evidence that the report was made in bad faith. This subdivision does not alter disclosure

48.1 responsibilities or obligations under the Rules of Criminal Procedure, except that when the  
48.2 identity of the reporter is relevant to a criminal prosecution the district court ~~shall~~ must  
48.3 conduct an in-camera review before determining whether to order disclosure of the reporter's  
48.4 identity.

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

48.6 Sec. 37. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision  
48.7 to read:

48.8 Subd. 6. **Application.** This section supersedes any inconsistent or contrary provision of  
48.9 law.

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

48.11 Sec. 38. **[256B.0647] REMITTANCE ADVICE MONETARY RECOVERY.**

48.12 (a) The commissioner may use the remittance advice process under Code of Federal  
48.13 Regulations, title 45, part 162.1601, as the notice to a vendor or provider when seeking  
48.14 monetary recovery using a department-administered information technology system for  
48.15 programmatically processed claims. The remittance advice must be delivered electronically  
48.16 and constitutes the sole notice to the provider. The commissioner must withhold the payments  
48.17 at issue when using the remittance advice as the notice.

48.18 (b) Providers may seek reconsideration of a remittance under this section by mailing a  
48.19 request to the commissioner. The reconsideration request must be received no later than 30  
48.20 calendar days from the posting of the remittance advice. A request for reconsideration does  
48.21 not stay the withholding of payments. The commissioner's disposition of a request for  
48.22 reconsideration is final and not subject to appeal under chapter 14. The request for  
48.23 reconsideration must include:

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

48.26 (2) the calculation that the individual or entity believes is correct;

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

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

48.31 (5) other information required by the commissioner.

49.1 (c) The commissioner may not use the remittance advice process as notice required  
49.2 under section 256B.064.

49.3 Sec. 39. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is  
49.4 amended to read:

49.5 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must  
49.6 be increased for services provided to medical assistance enrollees. To receive a rate increase,  
49.7 participating providers must meet demonstration project requirements and provide evidence  
49.8 of formal referral arrangements with providers delivering step-up or step-down levels of  
49.9 care. Providers that have enrolled in the demonstration project but have not met the provider  
49.10 standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under  
49.11 this subdivision until the date that the provider meets the provider standards in subdivision  
49.12 3. Services provided from July 1, 2022, to the date that the provider meets the provider  
49.13 standards under subdivision 3 shall be reimbursed at rates according to section 254B.0505,  
49.14 subdivision 1. Rate increases paid under this subdivision to a provider for services provided  
49.15 between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider  
49.16 is taking meaningful steps to meet demonstration project requirements that are not otherwise  
49.17 required by law, and the provider provides documentation to the commissioner, upon request,  
49.18 of the steps being taken.

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

49.23 (c) For outpatient individual and group substance use disorder services under section  
49.24 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed  
49.25 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on  
49.26 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in  
49.27 effect on December 31, 2020.

49.28 (d) Effective January 1, 2021, and contingent on annual federal approval, managed care  
49.29 plans and county-based purchasing plans must reimburse providers of the substance use  
49.30 disorder services meeting the criteria described in paragraph (a) who are employed by or  
49.31 under contract with the plan an amount that is at least equal to the fee-for-service base rate  
49.32 payment for the substance use disorder services described in paragraph (c). The commissioner  
49.33 must monitor the effect of this requirement on the rate of access to substance use disorder  
49.34 services and residential substance use disorder rates. Capitation rates paid to managed care

50.1 organizations and county-based purchasing plans must reflect the impact of this requirement.  
50.2 This paragraph expires if federal approval is not received at any time as required under this  
50.3 paragraph.

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

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

50.15 Sec. 40. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is  
50.16 amended to read:

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

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

50.22 (2) designate an individual as the agency's compliance officer who must perform the  
50.23 duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision  
50.24 7, paragraph (b);

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

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

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

51.1 individuals or entities maintained by the federal Department of Human Services Office of  
51.2 Inspector General;

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

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

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

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

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

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

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

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

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

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

51.30 (16) provide required EIDBI intervention observation and direction at least once per  
51.31 month. Notwithstanding subdivision 13, paragraph (1), required EIDBI intervention  
51.32 observation and direction under this clause may be conducted via telehealth provided that

52.1 no more than two consecutive monthly required EIDBI intervention observation and direction  
52.2 sessions under this clause are conducted via telehealth.

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

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

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

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

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

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

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

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

52.21 Sec. 41. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

52.22 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the  
52.23 Early Intensive Developmental and Behavioral Intervention Advisory Council and  
52.24 stakeholders, including agencies, professionals, parents of people with ASD or a related  
52.25 condition, and advocacy organizations, the commissioner shall determine if a shortage of  
52.26 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"  
52.27 means a lack of availability of providers who meet the EIDBI provider qualification  
52.28 requirements under subdivision 15 that results in the delay of access to timely services under  
52.29 this section, or that significantly impairs the ability of a provider agency to have sufficient  
52.30 providers to meet the requirements of this section. The commissioner shall consider  
52.31 geographic factors when determining the prevalence of a shortage. The commissioner may  
52.32 determine that a shortage exists only in a specific region of the state, multiple regions of

53.1 the state, or statewide. The commissioner shall also consider the availability of various types  
53.2 of treatment modalities covered under this section.

53.3 (b) The commissioner, in consultation with the Early Intensive Developmental and  
53.4 Behavioral Intervention Advisory Council and stakeholders, must establish processes and  
53.5 criteria for granting an exception under this paragraph. The commissioner may grant an  
53.6 exception only if the exception would not compromise a person's safety and not diminish  
53.7 the effectiveness of the treatment. The commissioner may establish an expiration date for  
53.8 an exception granted under this paragraph. The commissioner may grant an exception for  
53.9 the following:

53.10 (1) EIDBI provider qualifications under this section;

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

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

53.14 (c) If the commissioner, in consultation with the Early Intensive Developmental and  
53.15 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no  
53.16 longer exists, the commissioner must submit a notice that a shortage no longer exists to the  
53.17 chairs and ranking minority members of the senate and the house of representatives  
53.18 committees with jurisdiction over health and human services. The commissioner must post  
53.19 the notice for public comment for 30 days. The commissioner shall consider public comments  
53.20 before submitting to the legislature a request to end the shortage declaration. The  
53.21 commissioner shall not declare the shortage of EIDBI providers ended without direction  
53.22 from the legislature to declare it ended.

53.23 Sec. 42. Minnesota Statutes 2024, section 256B.69, subdivision 5a, is amended to read:

53.24 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and  
53.25 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner  
53.26 may issue separate contracts with requirements specific to services to medical assistance  
53.27 recipients age 65 and older.

53.28 (b) A prepaid health plan providing covered health services for eligible persons pursuant  
53.29 to chapters 256B and 256L is responsible for complying with the terms of its contract with  
53.30 the commissioner. Requirements applicable to managed care programs under chapters 256B  
53.31 and 256L established after the effective date of a contract with the commissioner take effect  
53.32 when the contract is next issued or renewed.

54.1 (c) The commissioner shall withhold five percent of managed care plan payments under  
 54.2 this section and county-based purchasing plan payments under section 256B.692 for the  
 54.3 prepaid medical assistance program pending completion of performance targets. Each  
 54.4 performance target must be quantifiable, objective, measurable, and reasonably attainable,  
 54.5 except in the case of a performance target based on a federal or state law or rule. Criteria  
 54.6 for assessment of each performance target must be outlined in writing prior to the contract  
 54.7 effective date. Clinical or utilization performance targets and their related criteria must  
 54.8 consider evidence-based research and reasonable interventions when available or applicable  
 54.9 to the populations served, and must be developed with input from external clinical experts  
 54.10 and stakeholders, including managed care plans, county-based purchasing plans, and  
 54.11 providers. The managed care or county-based purchasing plan must demonstrate, to the  
 54.12 commissioner's satisfaction, that the data submitted regarding attainment of the performance  
 54.13 target is accurate. The commissioner shall periodically change the administrative measures  
 54.14 used as performance targets in order to improve plan performance across a broader range  
 54.15 of administrative services. The performance targets must include measurement of plan  
 54.16 efforts to contain spending on health care services and administrative activities. The  
 54.17 commissioner may adopt plan-specific performance targets that take into account factors  
 54.18 affecting only one plan, including characteristics of the plan's enrollee population. The  
 54.19 withheld funds must be returned no sooner than July of the following year if performance  
 54.20 targets in the contract are achieved. The commissioner may exclude special demonstration  
 54.21 projects under subdivision 23.

54.22 (d) The commissioner shall require that managed care plans:

54.23 (1) use the assessment and authorization processes, forms, timelines, standards,  
 54.24 documentation, and data reporting requirements, protocols, billing processes, and policies  
 54.25 consistent with medical assistance fee-for-service or the Department of Human Services  
 54.26 contract requirements for all personal care assistance services under section 256B.0659 and  
 54.27 community first services and supports under section 256B.85;

54.28 (2) by January 30 of each year that follows a rate increase for any aspect of services  
 54.29 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking  
 54.30 minority members of the legislative committees with jurisdiction over rates determined  
 54.31 under section 256B.851 of the amount of the rate increase that is paid to each personal care  
 54.32 assistance provider agency with which the plan has a contract; ~~and~~

54.33 (3) use a six-month timely filing standard and provide an exemption to the timely filing  
 54.34 timeliness for the resubmission of claims where there has been a denial, request for more  
 54.35 information, or system issue;

55.1 (4) have in place a prepayment review process for all claims that includes claims edit  
55.2 processing and policies consistent with the procedures under section 256B.0447; and

55.3 (5) publish metrics related to program integrity actions and outcomes on a publicly  
55.4 available website.

55.5 (e) Effective for services rendered on or after January 1, 2013, through December 31,  
55.6 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under  
55.7 this section and county-based purchasing plan payments under section 256B.692 for the  
55.8 prepaid medical assistance program. The withheld funds must be returned no sooner than  
55.9 July 1 and no later than July 31 of the following year. The commissioner may exclude  
55.10 special demonstration projects under subdivision 23.

55.11 (f) Effective for services rendered on or after January 1, 2014, the commissioner shall  
55.12 withhold three percent of managed care plan payments under this section and county-based  
55.13 purchasing plan payments under section 256B.692 for the prepaid medical assistance  
55.14 program. The withheld funds must be returned no sooner than July 1 and no later than July  
55.15 31 of the following year. The commissioner may exclude special demonstration projects  
55.16 under subdivision 23.

55.17 (g) A managed care plan or a county-based purchasing plan under section 256B.692  
55.18 may include as admitted assets under section 62D.044 any amount withheld under this  
55.19 section that is reasonably expected to be returned.

55.20 (h) Contracts between the commissioner and a prepaid health plan are exempt from the  
55.21 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and  
55.22 7.

55.23 (i) The return of the withhold under paragraphs (e) and (f) is not subject to the  
55.24 requirements of paragraph (c).

55.25 (j) Managed care plans and county-based purchasing plans shall maintain current and  
55.26 fully executed agreements for all subcontractors, including bargaining groups, for  
55.27 administrative services that are expensed to the state's public health care programs.  
55.28 Subcontractor agreements determined to be material, as defined by the commissioner after  
55.29 taking into account state contracting and relevant statutory requirements, must be in the  
55.30 form of a written instrument or electronic document containing the elements of offer,  
55.31 acceptance, consideration, payment terms, scope, duration of the contract, and how the  
55.32 subcontractor services relate to state public health care programs. Upon request, the  
55.33 commissioner shall have access to all subcontractor documentation under this paragraph.

56.1 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant  
56.2 to section 13.02.

56.3 (k) The commissioner has the right to recover from a managed care plan the full monetary  
56.4 amount of any claims identified as improperly paid during audits or investigations by the  
56.5 commissioner or the commissioner's contractors or the Centers for Medicare and Medicaid  
56.6 Services.

56.7 Sec. 43. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision  
56.8 to read:

56.9 Subd. 10a. **Data sharing for program integrity.** If the commissioner receives a written  
56.10 report from a managed care plan that has reason to believe that a provider, vendor, managed  
56.11 care employee, subcontractor, or enrollee committed fraud under this chapter or chapter  
56.12 256L, the commissioner must provide summary data, as defined in section 13.02, subdivision  
56.13 19, from the report to other managed care plans contracted under this section within ten  
56.14 days of receiving the report. Nothing in this subdivision allows release of information that  
56.15 is nonpublic data pursuant to section 13.02, subdivision 9.

56.16 Sec. 44. Minnesota Statutes 2024, section 256B.69, subdivision 37, is amended to read:

56.17 Subd. 37. **Networks.** (a) The commissioner shall ensure that a managed care  
56.18 organization's network providers are enrolled with the commissioner as medical assistance  
56.19 providers, and that the providers comply with the provider disclosure, screening, and  
56.20 enrollment requirements in Code of Federal Regulations, part 42, section 455. A provider  
56.21 that has a network provider contract with the managed care organization is not required to  
56.22 provide services to a medical assistance or MinnesotaCare recipient who is receiving services  
56.23 through the fee-for-service system.

56.24 (b) A managed care organization may enter into a network provider contract with a  
56.25 provider that is not a medical assistance provider for a period of up to 120 days pending the  
56.26 outcome of the medical assistance provider enrollment process. A managed care organization  
56.27 must terminate the contract upon notification that the provider cannot be enrolled as a  
56.28 medical assistance provider or upon expiration of the 120-day period if notification has not  
56.29 been received within that period. The managed care organization must notify each affected  
56.30 enrollee of the provider contract termination.

56.31 (c) For purposes of this subdivision, "network provider" means any provider, group of  
56.32 providers, entity with a network provider agreement with the managed care organization,  
56.33 or subcontractor that receives payments from the managed care organization either directly

57.1 or indirectly to provide services under a managed care contract between the commissioner  
57.2 and the managed care organization.

57.3 (d) A managed care organization is not required to include a provider in its network  
57.4 before approving the provider's credentials in accordance with section 62Q.097.

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

57.6 Sec. 45. **MANDATORY COMPLIANCE TRAINING FOR CURRENTLY**  
57.7 **ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

57.8 The owners and employees of any medical assistance provider agency subject to the  
57.9 requirements of Minnesota Statutes, section 256B.0444, subdivision 2, and enrolled before  
57.10 January 1, 2027, must complete initial compliance training by January 1, 2028. Owners and  
57.11 employees of PCA and CFSS agencies who enrolled before January 1, 2027, and have  
57.12 previously completed training under Minnesota Statutes, section 256B.0659, subdivision  
57.13 21, paragraph (c), or 256B.85, subdivision 12, paragraph (c), are not subject to the initial  
57.14 training requirements of this section but must repeat the compliance training prior to  
57.15 revalidation as a medical assistance provider.

57.16 **ARTICLE 2**

57.17 **DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL**  
57.18 **POLICY**

57.19 Section 1. Minnesota Statutes 2024, section 245.095, subdivision 2, is amended to read:

57.20 Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions have the  
57.21 meanings given.

57.22 (b) "Associated entity" means a provider or vendor owned or controlled by an excluded  
57.23 individual.

57.24 (c) "Associated individual" means an individual or entity that has a relationship with  
57.25 the business or its owners or controlling individuals, such that the individual or entity would  
57.26 have knowledge of the financial practices of the program in question.

57.27 (d) "Convicted" means a judgment of conviction has been entered by a federal, state, or  
57.28 local court, regardless of whether an appeal from the judgment is pending, and includes a  
57.29 stay of adjudication, a court-ordered diversion program, or a plea of guilty or nolo contendere.

57.30 (e) "Credible allegation of fraud" means an allegation that has been verified by the  
57.31 commissioner from any source, including but not limited to:

58.1 (1) fraud hotline complaints;

58.2 (2) claims data mining;

58.3 (3) patterns identified through provider audits, civil false claims cases, and law  
58.4 enforcement investigations; and

58.5 (4) court filings and other legal documents, including but not limited to police reports,  
58.6 complaints, indictments, informations, affidavits, declarations, and search warrants.

58.7 ~~(d)~~ (f) "Excluded" means removed under other authorities from a program administered  
58.8 by a Minnesota state or federal agency, including. Excluded includes but is not limited to:

58.9 (1) a final determination to stop payments;

58.10 (2) a conclusive background study disqualification, except for a disqualification issued  
58.11 under section 245C.15, subdivision 4c, that has not been set aside or had a variance granted  
58.12 under section 245C.30; and

58.13 (3) a final agency decision regarding a denial of a license application.

58.14 (g) "Fraud" has the meaning given in section 256B.02, subdivision 20.

58.15 ~~(e)~~ (h) "Individual" means a natural person providing products or services as a provider  
58.16 or vendor.

58.17 ~~(f)~~ (i) "Provider" means any entity, individual, owner, controlling individual, license  
58.18 holder, director, or managerial official of an entity receiving payment from a program  
58.19 administered by a Minnesota state or federal agency.

58.20 Sec. 2. Minnesota Statutes 2024, section 245.095, subdivision 5, is amended to read:

58.21 Subd. 5. **Withholding of payments.** (a) Except as otherwise provided by state or federal  
58.22 law, the commissioner may withhold payments to a provider, vendor, individual, associated  
58.23 individual, or associated entity in any program administered by the commissioner if the  
58.24 commissioner determines:

58.25 (1) there is a credible allegation of fraud for which an investigation is pending for a  
58.26 program administered by a Minnesota state or federal agency;

58.27 (2) the individual, the entity, or an associated individual or entity was convicted of a  
58.28 crime, in state or federal court, for an offense that involves fraud or theft against a program  
58.29 administered by the commissioner or another state or federal agency;

58.30 (3) the provider is operating after a state or federal agency orders the suspension,  
58.31 revocation, or decertification of the provider's license or certification, or if the provider is

59.1 subject to a temporary immediate suspension, regardless of whether the action is under  
59.2 appeal; or

59.3 (4) the provider, vendor, individual, associated individual, or associated entity, including  
59.4 those receiving funds under any contract or registered program, has a background study  
59.5 disqualification under section 245C.15, subdivisions 1 to 4b, that has not been set aside and  
59.6 for which no variance has been issued.

59.7 ~~(b) For purposes of this subdivision, "credible allegation of fraud" means an allegation~~  
59.8 ~~that has been verified by the commissioner from any source, including but not limited to:~~

59.9 ~~(1) fraud hotline complaints;~~

59.10 ~~(2) claims data mining;~~

59.11 ~~(3) patterns identified through provider audits, civil false claims cases, and law~~  
59.12 ~~enforcement investigations; and~~

59.13 ~~(4) court filings and other legal documents, including but not limited to police reports,~~  
59.14 ~~complaints, indictments, informations, affidavits, declarations, and search warrants.~~

59.15 ~~(e)~~ (b) The commissioner must send notice of the withholding of payments within five  
59.16 days of taking such action. The notice must:

59.17 (1) state that payments are being withheld according to this subdivision;

59.18 (2) set forth the general allegations related to the withholding action, except the notice  
59.19 need not disclose specific information concerning an ongoing investigation;

59.20 (3) state that the withholding is for a temporary period and cite the circumstances under  
59.21 which the withholding will be terminated; and

59.22 (4) inform the provider, vendor, individual, associated individual, or associated entity  
59.23 of the right to submit written evidence to contest the withholding action for consideration  
59.24 by the commissioner.

59.25 ~~(d)~~ (c) If the commissioner withholds payments under this subdivision, the provider,  
59.26 vendor, individual, associated individual, or associated entity has a right to request  
59.27 administrative reconsideration. A request for administrative reconsideration must be made  
59.28 in writing, state with specificity the reasons the payment withholding decision is in error,  
59.29 and include documents to support the request. Within 60 days from receipt of the request,  
59.30 the commissioner shall judiciously review allegations, facts, evidence available to the  
59.31 commissioner, and information submitted by the provider, vendor, individual, associated

60.1 individual, or associated entity to determine whether the payment withholding should remain  
60.2 in place.

60.3 ~~(e)~~ (d) The commissioner shall stop withholding payments if the commissioner determines  
60.4 there is insufficient evidence of fraud by the provider, vendor, individual, associated  
60.5 individual, or associated entity or when legal proceedings relating to the alleged fraud are  
60.6 completed, unless the commissioner has sent notice under subdivision 3 to the provider,  
60.7 vendor, individual, associated individual, or associated entity.

60.8 ~~(f)~~ (e) The withholding of payments under this section is a temporary action and is not  
60.9 subject to appeal under section 256.045 or chapter 14.

60.10 (f) Section 15.013 does not apply to the commissioner taking action under this section.

60.11 Sec. 3. Minnesota Statutes 2024, section 245A.02, subdivision 13, is amended to read:

60.12 Subd. 13. **Individual who is related.** "Individual who is related" means a spouse, a  
60.13 parent, a birth or adopted child or stepchild, a stepparent, a stepbrother, a stepsister, a niece,  
60.14 a nephew, an adoptive parent, a grandparent, a sibling, an aunt, an uncle, a cousin, or a legal  
60.15 guardian. Individual who is related includes an individual who has a relationship named in  
60.16 this subdivision through marriage.

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

60.18 Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended  
60.19 to read:

60.20 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

60.21 (1) residential or nonresidential programs that are provided to a person by an individual  
60.22 who is related;

60.23 (2) nonresidential programs that are provided by an unrelated individual to persons from  
60.24 a single related family;

60.25 (3) residential or nonresidential programs that are provided to adults who do not misuse  
60.26 substances or have a substance use disorder, a mental illness, a developmental disability, a  
60.27 functional impairment, or a physical disability;

60.28 (4) sheltered workshops or work activity programs that are certified by the commissioner  
60.29 of employment and economic development;

60.30 (5) programs operated by a public school for children 33 months or older;

61.1 (6) nonresidential programs primarily for children that provide care or supervision for  
61.2 periods of less than three hours a day while the child's parent or legal guardian is in the  
61.3 same building as the nonresidential program or present within another building that is  
61.4 directly contiguous to the building in which the nonresidential program is located;

61.5 (7) nursing homes or hospitals licensed by the commissioner of health except as specified  
61.6 under section 245A.02;

61.7 (8) board and lodge facilities licensed by the commissioner of health that do not provide  
61.8 children's residential services under Minnesota Rules, chapter 2960, mental health or  
61.9 substance use disorder treatment;

61.10 (9) programs licensed by the commissioner of corrections;

61.11 (10) recreation programs for children or adults that are operated or approved by a park  
61.12 and recreation board whose primary purpose is to provide social and recreational activities;

61.13 (11) noncertified boarding care homes unless they provide services for five or more  
61.14 persons whose primary diagnosis is mental illness or a developmental disability;

61.15 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art  
61.16 programs, and nonresidential programs for children provided for a cumulative total of less  
61.17 than 30 days in any 12-month period;

61.18 (13) residential programs for persons with mental illness, that are located in hospitals;

61.19 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter  
61.20 4630;

61.21 (15) mental health outpatient services for adults with mental illness or children with  
61.22 mental illness;

61.23 (16) residential programs serving school-age children whose sole purpose is cultural or  
61.24 educational exchange, until the commissioner adopts appropriate rules;

61.25 (17) community support services programs as defined in section 245.462, subdivision  
61.26 6, and family community support services as defined in section 245.4871, subdivision 17;

61.27 (18) assisted living facilities licensed by the commissioner of health under chapter 144G;

61.28 (19) substance use disorder treatment activities of licensed professionals in private  
61.29 practice as defined in section 245G.01, subdivision 17;

62.1 (20) consumer-directed community support service funded under the Medicaid waiver  
62.2 for persons with developmental disabilities when the individual who provided the service  
62.3 is:

62.4 (i) the same individual who is the direct payee of these specific waiver funds or paid by  
62.5 a fiscal agent, fiscal intermediary, or employer of record; and

62.6 (ii) not otherwise under the control of a residential or nonresidential program that is  
62.7 required to be licensed under this chapter when providing the service;

62.8 (21) a county that is an eligible vendor under section 254B.0501 to provide care  
62.9 coordination and comprehensive assessment services;

62.10 (22) a recovery community organization that is an eligible vendor under section  
62.11 254B.0501 to provide peer recovery support services; or

62.12 (23) programs licensed by the commissioner of children, youth, and families in chapter  
62.13 142B.

62.14 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a  
62.15 building in which a nonresidential program is located if it shares a common wall with the  
62.16 building in which the nonresidential program is located or is attached to that building by  
62.17 skyway, tunnel, atrium, or common roof.

62.18 (c) Except for the home and community-based services identified in section 245D.03,  
62.19 subdivision 1, nothing in this chapter shall be construed to require licensure for any services  
62.20 provided and funded according to an approved federal waiver plan where licensure is  
62.21 specifically identified as not being a condition for the services and funding.

62.22 (d) Notwithstanding section 245A.02, subdivision 13, programs initially licensed prior  
62.23 to July 1, 2026, may continue to operate under and must comply with the definition of  
62.24 related individual in Minnesota Statutes 2024, section 245A.02, subdivision 13, until the  
62.25 service recipient related to the license holder is no longer receiving services licensed under  
62.26 this chapter.

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

62.28 Sec. 5. Minnesota Statutes 2024, section 245A.043, subdivision 2, is amended to read:

62.29 Subd. 2. **Change in ownership.** ~~(a)~~ If the commissioner determines that there is a change  
62.30 in ownership, the commissioner shall require submission of a new license application. This  
62.31 subdivision does not apply to a licensed program or service located in a home where the  
62.32 license holder resides. A change in ownership occurs when:

63.1 (1) ~~except as provided in paragraph (b)~~; the license holder sells or transfers 100 percent  
63.2 of the property, stock, or assets;

63.3 (2) the license holder merges with another organization;

63.4 (3) the license holder consolidates with two or more organizations, resulting in the  
63.5 creation of a new organization;

63.6 (4) there is a change to the federal tax identification number associated with the license  
63.7 holder; or

63.8 (5) ~~except as provided in paragraph (b)~~; all controlling individuals for the original license  
63.9 have changed.

63.10 ~~(b) For changes under paragraph (a), clause (1) or (5), no change in ownership has~~  
63.11 ~~occurred and a new license application is not required if at least one controlling individual~~  
63.12 ~~has been affiliated as a controlling individual for the license for at least the previous 12~~  
63.13 ~~months immediately preceding the change.~~

63.14 **EFFECTIVE DATE.** This section is effective October 1, 2026.

63.15 Sec. 6. Minnesota Statutes 2025 Supplement, section 245A.043, subdivision 2a, is amended  
63.16 to read:

63.17 Subd. 2a. **Review of change in ownership.** ~~(a)~~ After a change in ownership under  
63.18 subdivision 2, ~~paragraph (a)~~, the commissioner may complete a review for all new license  
63.19 holders within 12 months after the new license is issued.

63.20 ~~(b) For all license holders subject to the exception in subdivision 2, paragraph (b), the~~  
63.21 ~~license holder must notify the commissioner of the date of the change in controlling~~  
63.22 ~~individuals pursuant to section 245A.04, subdivision 7a, and the commissioner may complete~~  
63.23 ~~a review within 12 months following the change.~~

63.24 **EFFECTIVE DATE.** This section is effective October 1, 2026.

63.25 Sec. 7. Minnesota Statutes 2024, section 245A.07, subdivision 2a, is amended to read:

63.26 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of  
63.27 receipt of the license holder's timely appeal, the commissioner shall request assignment of  
63.28 an administrative law judge. The request must include a proposed date, time, and place of  
63.29 a hearing. A hearing must be conducted by an administrative law judge within 30 calendar  
63.30 days of the request for assignment, unless an extension is requested by either party and  
63.31 granted by the administrative law judge for good cause. The commissioner shall issue a

64.1 notice of hearing by certified mail or personal service at least ten working days before the  
64.2 hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary  
64.3 immediate suspension should remain in effect pending the commissioner's final order under  
64.4 section 245A.08, regarding a licensing sanction issued under subdivision 3 following the  
64.5 immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the  
64.6 burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only  
64.7 ~~if the commissioner's demonstration~~ commissioner demonstrates that reasonable cause exists  
64.8 to believe that the license holder's or controlling individual's actions or failure to comply  
64.9 with applicable law or rule poses, or the actions of other individuals or conditions in the  
64.10 program poses an imminent risk of harm to the health, safety, or rights of persons served  
64.11 by the program. "Reasonable cause" means there exist specific articulable facts or  
64.12 circumstances which provide the commissioner with a reasonable suspicion that there is an  
64.13 imminent risk of harm to the health, safety, or rights of persons served by the program.  
64.14 When the commissioner has determined there is reasonable cause to order the temporary  
64.15 immediate suspension of a license based on a violation of safe sleep requirements, as defined  
64.16 in section 245A.1435, the commissioner is not required to demonstrate that an infant died  
64.17 or was injured as a result of the safe sleep violations. For suspensions under subdivision 2,  
64.18 paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision  
64.19 ~~shall be limited to~~ is met only if the commissioner demonstrates  
64.20 by a preponderance of the evidence that, since the license was revoked, the  
64.21 license holder committed additional violations of law or rule which may adversely affect  
64.22 the health or safety of persons served by the program.

64.23 (b) The administrative law judge shall issue findings of fact, conclusions, and a  
64.24 recommendation within ten working days from the date of hearing. The parties shall have  
64.25 ten calendar days to submit exceptions to the administrative law judge's report. The record  
64.26 shall close at the end of the ten-day period for submission of exceptions. The commissioner's  
64.27 final order shall be issued within ten working days from the close of the record. When an  
64.28 appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner  
64.29 shall issue a final order affirming the temporary immediate suspension within ten calendar  
64.30 days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days  
64.31 after an immediate suspension has been issued and the license holder has not submitted a  
64.32 timely appeal under subdivision 2, paragraph (b), or within 90 calendar days after a final  
64.33 order affirming an immediate suspension, the commissioner shall determine:

65.1 (1) whether a final licensing sanction shall be issued under subdivision 3, paragraph (a),  
65.2 clauses (1) to ~~(6)~~ (5). The license holder shall continue to be prohibited from operation of  
65.3 the program during this 90-day period; or

65.4 (2) whether the outcome of related, ongoing investigations or judicial proceedings are  
65.5 necessary to determine if a final licensing sanction under subdivision 3, paragraph (a),  
65.6 clauses (1) to ~~(6)~~ (5), will be issued and whether persons served by the program remain at  
65.7 an imminent risk of harm during the investigation period or proceedings. If so, the  
65.8 commissioner shall issue a suspension order under subdivision 3, paragraph (a), clause ~~(7)~~.  
65.9 (6); or

65.10 (3) whether the license holder or controlling individual remains the subject of a pending  
65.11 administrative, civil, or criminal investigation or subject to an administrative or civil action  
65.12 related to fraud against a program administered by a state or federal agency. If so, the  
65.13 commissioner shall issue a suspension order under subdivision 3, paragraph (a), clause (6).

65.14 (c) When the final order under paragraph (b) affirms an immediate suspension, or the  
65.15 license holder does not submit a timely appeal of the immediate suspension, and a final  
65.16 licensing sanction is issued under subdivision 3 and the license holder appeals that sanction,  
65.17 the license holder continues to be prohibited from operation of the program pending a final  
65.18 commissioner's order under section 245A.08, subdivision 5, regarding the final licensing  
65.19 sanction.

65.20 (d) The license holder shall continue to be prohibited from operation of the program  
65.21 while a suspension order issued under paragraph (b), clause (2) or (3), remains in effect.

65.22 (e) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof  
65.23 in expedited hearings under this subdivision ~~shall be limited to~~ is met only if the  
65.24 ~~commissioner's demonstration~~ commissioner demonstrates by a preponderance of the  
65.25 evidence that a criminal complaint and warrant or summons was issued for the license holder  
65.26 or controlling individual that was not dismissed, and that the criminal charge is an offense  
65.27 that involves fraud or theft against a program administered by the commissioner.

65.28 (f) For suspensions under subdivision 2, paragraph (c), the burden of proof in expedited  
65.29 hearings under this subdivision is met only if the commissioner demonstrates by a  
65.30 preponderance of the evidence that the license holder or controlling individual is the subject  
65.31 of a pending administrative, civil, or criminal investigation or is subject to an administrative  
65.32 or civil action related to fraud against a program administered by a state or federal agency.

66.1 Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.07, subdivision 3, is amended  
66.2 to read:

66.3 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend  
66.4 or revoke a license, or impose a fine if:

66.5 (1) a license holder fails to comply fully with applicable laws or rules including but not  
66.6 limited to the requirements of this chapter and chapter 245C;

66.7 (2) a license holder, a controlling individual, or an individual living in the household  
66.8 where the licensed services are provided or is otherwise subject to a background study has  
66.9 been disqualified and the disqualification was not set aside and no variance has been granted;

66.10 (3) a license holder knowingly withholds relevant information from or gives false or  
66.11 misleading information to the commissioner in connection with an application for a license,  
66.12 in connection with the background study status of an individual, during an investigation,  
66.13 or regarding compliance with applicable laws or rules;

66.14 (4) a license holder is excluded from any program administered by the commissioner  
66.15 under section 245.095;

66.16 (5) revocation is required under section 245A.04, subdivision 7, paragraph (d); or

66.17 (6) suspension is necessary under subdivision 2a, paragraph (b), clause (2) or (3).

66.18 A license holder who has had a license issued under this chapter suspended, revoked,  
66.19 or has been ordered to pay a fine must be given notice of the action by certified mail, by  
66.20 personal service, or through the provider licensing and reporting hub. If mailed, the notice  
66.21 must be mailed to the address shown on the application or the last known address of the  
66.22 license holder. The notice must state in plain language the reasons the license was suspended  
66.23 or revoked, or a fine was ordered.

66.24 (b) If the license was suspended or revoked, the notice must inform the license holder  
66.25 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts  
66.26 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking  
66.27 a license. The appeal of an order suspending or revoking a license must be made in writing  
66.28 by certified mail, by personal service, or through the provider licensing and reporting hub.  
66.29 If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar  
66.30 days after the license holder receives notice that the license has been suspended or revoked.  
66.31 If a request is made by personal service, it must be received by the commissioner within  
66.32 ten calendar days after the license holder received the order. If the order is issued through  
66.33 the provider hub, the appeal must be received by the commissioner within ten calendar days

67.1 from the date the commissioner issued the order through the hub. Except as provided in  
67.2 subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order  
67.3 suspending or revoking a license, the license holder may continue to operate the program  
67.4 as provided in section 245A.04, subdivision 7, paragraphs (i) and (j), until the commissioner  
67.5 issues a final order on the suspension or revocation.

67.6 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license  
67.7 holder of the responsibility for payment of fines and the right to a contested case hearing  
67.8 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an  
67.9 order to pay a fine must be made in writing by certified mail, by personal service, or through  
67.10 the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent  
67.11 to the commissioner within ten calendar days after the license holder receives notice that  
67.12 the fine has been ordered. If a request is made by personal service, it must be received by  
67.13 the commissioner within ten calendar days after the license holder received the order. If the  
67.14 order is issued through the provider hub, the appeal must be received by the commissioner  
67.15 within ten calendar days from the date the commissioner issued the order through the hub.

67.16 (2) The license holder shall pay the fines assessed on or before the payment date specified.  
67.17 If the license holder fails to fully comply with the order, the commissioner may issue a  
67.18 second fine or suspend the license until the license holder complies. If the license holder  
67.19 receives state funds, the state, county, or municipal agencies or departments responsible for  
67.20 administering the funds shall withhold payments and recover any payments made while the  
67.21 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine  
67.22 until the commissioner issues a final order.

67.23 (3) A license holder shall promptly notify the commissioner of human services, in writing,  
67.24 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the  
67.25 commissioner determines that a violation has not been corrected as indicated by the order  
67.26 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify  
67.27 the license holder by certified mail, by personal service, or through the provider licensing  
67.28 and reporting hub that a second fine has been assessed. The license holder may appeal the  
67.29 second fine as provided under this subdivision.

67.30 (4) Fines shall be assessed as follows:

67.31 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a  
67.32 child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557  
67.33 for which the license holder is determined responsible for the maltreatment under section  
67.34 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

68.1 (ii) if the commissioner determines that a determination of maltreatment for which the  
68.2 license holder is responsible is the result of maltreatment that meets the definition of serious  
68.3 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit  
68.4 \$5,000;

68.5 (iii) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule  
68.6 governing matters of health, safety, or supervision, including but not limited to the provision  
68.7 of adequate staff-to-child or adult ratios, and failure to comply with background study  
68.8 requirements under chapter 245C; and

68.9 (iv) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule  
68.10 other than those subject to a \$5,000, \$1,000, or \$200 fine in items (i) to (iii).

68.11 For purposes of this section, "occurrence" means each violation identified in the  
68.12 commissioner's fine order. Fines assessed against a license holder that holds a license to  
68.13 provide home and community-based services, as identified in section 245D.03, subdivision  
68.14 1, and a community residential setting or day services facility license under chapter 245D  
68.15 where the services are provided, may be assessed against both licenses for the same  
68.16 occurrence, but the combined amount of the fines shall not exceed the amount specified in  
68.17 this clause for that occurrence.

68.18 (5) When a fine has been assessed, the license holder may not avoid payment by closing,  
68.19 selling, or otherwise transferring the licensed program to a third party. In such an event, the  
68.20 license holder will be personally liable for payment. In the case of a corporation, each  
68.21 controlling individual is personally and jointly liable for payment.

68.22 (d) Except for background study violations involving the failure to comply with an order  
68.23 to immediately remove an individual or an order to provide continuous, direct supervision,  
68.24 the commissioner shall not issue a fine under paragraph (c) relating to a background study  
68.25 violation to a license holder who self-corrects a background study violation before the  
68.26 commissioner discovers the violation. A license holder who has previously exercised the  
68.27 provisions of this paragraph to avoid a fine for a background study violation may not avoid  
68.28 a fine for a subsequent background study violation unless at least 365 days have passed  
68.29 since the license holder self-corrected the earlier background study violation.

68.30 Sec. 9. Minnesota Statutes 2024, section 256B.04, subdivision 10, is amended to read:

68.31 Subd. 10. **Investigation of certain claims.** The commissioner must establish by rule  
68.32 general criteria and procedures for the identification and prompt investigation of suspected  
68.33 medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment

69.1 of claims for services not reasonable or medically necessary, or false statement or  
69.2 representation of material facts by a vendor of medical care, ~~and for the imposition of~~  
69.3 ~~sanctions against a vendor of medical care.~~ The commissioner must utilize both prepayment  
69.4 and postpayment review systems to review claims submitted by vendors. Payment of claims,  
69.5 including payments made after a prepayment review, does not prohibit the commissioner  
69.6 from completing a postpayment claims review and taking additional administrative actions  
69.7 or monetary recovery against a vendor. If it appears to the state agency that a vendor of  
69.8 medical care may have acted in a manner warranting civil or criminal proceedings, it shall  
69.9 so inform the attorney general in writing.

69.10 Sec. 10. Minnesota Statutes 2025 Supplement, section 256B.051, subdivision 6, is amended  
69.11 to read:

69.12 Subd. 6. **Agency qualifications and duties.** An agency is eligible for reimbursement  
69.13 under this section only if the agency:

69.14 (1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk  
69.15 assessment under subdivision 6a;

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

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

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

69.22 (5) provides at the time of enrollment, reenrollment, and revalidation in a format  
69.23 determined by the commissioner, proof of surety bond coverage for each business location  
69.24 providing services. Upon new enrollment, or if the provider's medical assistance revenue  
69.25 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety  
69.26 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over  
69.27 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond  
69.28 must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually,  
69.29 and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action  
69.30 to obtain monetary recovery or sanctions from a surety bond must occur within six years  
69.31 from the date the debt is affirmed by a final agency decision. An agency decision is final  
69.32 when the right to appeal the debt has been exhausted or the time to appeal has expired under  
69.33 section 256B.064;

70.1 (6) directly provides housing stabilization services using employees of the agency and  
70.2 not by using a subcontractor or reporting agent;

70.3 (7) ensures all controlling individuals and employees of the agency complete annual  
70.4 vulnerable adult training; and

70.5 (8) completes compliance training as required under subdivision 6b.

70.6 Sec. 11. Minnesota Statutes 2025 Supplement, section 256B.0659, subdivision 21, is  
70.7 amended to read:

70.8 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**  
70.9 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of  
70.10 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in  
70.11 a format determined by the commissioner, information and documentation that includes,  
70.12 but is not limited to, the following:

70.13 (1) the personal care assistance provider agency's current contact information including  
70.14 address, telephone number, and email address;

70.15 (2) proof of surety bond coverage for each business location providing services. Upon  
70.16 new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up  
70.17 to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If  
70.18 the Medicaid revenue in the previous year is over \$300,000, the provider agency must  
70.19 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the  
70.20 commissioner, must be ~~renewed~~ purchased new annually, and must allow for recovery of  
70.21 costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or  
70.22 sanctions from a surety bond must occur within six years from the date the debt is affirmed  
70.23 by a final agency decision. An agency decision is final when the right to appeal the debt  
70.24 has been exhausted or the time to appeal has expired under section 256B.064;

70.25 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location  
70.26 providing service;

70.27 (4) proof of workers' compensation insurance coverage identifying the business location  
70.28 where personal care assistance services are provided;

70.29 (5) proof of liability insurance coverage identifying the business location where personal  
70.30 care assistance services are provided and naming the department as a certificate holder;

70.31 (6) a copy of the personal care assistance provider agency's written policies and  
70.32 procedures including: hiring of employees; training requirements; service delivery; and

71.1 employee and consumer safety including process for notification and resolution of consumer  
71.2 grievances, identification and prevention of communicable diseases, and employee  
71.3 misconduct;

71.4 (7) copies of all other forms the personal care assistance provider agency uses in the  
71.5 course of daily business including, but not limited to:

71.6 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet  
71.7 varies from the standard time sheet for personal care assistance services approved by the  
71.8 commissioner, and a letter requesting approval of the personal care assistance provider  
71.9 agency's nonstandard time sheet;

71.10 (ii) the personal care assistance provider agency's template for the personal care assistance  
71.11 care plan; and

71.12 (iii) the personal care assistance provider agency's template for the written agreement  
71.13 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

71.14 (8) a list of all training and classes that the personal care assistance provider agency  
71.15 requires of its staff providing personal care assistance services;

71.16 (9) documentation that the personal care assistance provider agency and staff have  
71.17 successfully completed all the training required by this section, including the requirements  
71.18 under subdivision 11, paragraph (d), if enhanced personal care assistance services are  
71.19 provided and submitted for an enhanced rate under subdivision 17a;

71.20 (10) documentation of the agency's marketing practices;

71.21 (11) disclosure of ownership, leasing, or management of all residential properties that  
71.22 is used or could be used for providing home care services;

71.23 (12) documentation that the agency will use the following percentages of revenue  
71.24 generated from the medical assistance rate paid for personal care assistance services for  
71.25 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal  
71.26 care assistance choice option and 72.5 percent of revenue from other personal care assistance  
71.27 providers. The revenue generated by the qualified professional and the reasonable costs  
71.28 associated with the qualified professional shall not be used in making this calculation; and

71.29 (13) effective May 15, 2010, documentation that the agency does not burden recipients'  
71.30 free exercise of their right to choose service providers by requiring personal care assistants  
71.31 to sign an agreement not to work with any particular personal care assistance recipient or  
71.32 for another personal care assistance provider agency after leaving the agency and that the

72.1 agency is not taking action on any such agreements or requirements regardless of the date  
72.2 signed.

72.3 (b) Personal care assistance provider agencies shall provide the information specified  
72.4 in paragraph (a) to the commissioner at the time the personal care assistance provider agency  
72.5 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect  
72.6 the information specified in paragraph (a) from all personal care assistance providers  
72.7 beginning July 1, 2009.

72.8 (c) All personal care assistance provider agencies shall require all employees in  
72.9 management and supervisory positions and owners of the agency who are active in the  
72.10 day-to-day management and operations of the agency to complete mandatory training as  
72.11 determined by the commissioner before submitting an application for enrollment of the  
72.12 agency as a provider. All personal care assistance provider agencies shall also require  
72.13 qualified professionals to complete the training required by subdivision 13 before submitting  
72.14 an application for enrollment of the agency as a provider. Employees in management and  
72.15 supervisory positions and owners who are active in the day-to-day operations of an agency  
72.16 who have completed the required training as an employee with a personal care assistance  
72.17 provider agency do not need to repeat the required training if they are hired by another  
72.18 agency, if they have completed the training within the past three years. By September 1,  
72.19 2010, the required training must be available with meaningful access according to title VI  
72.20 of the Civil Rights Act and federal regulations adopted under that law or any guidance from  
72.21 the United States Health and Human Services Department. The required training must be  
72.22 available online or by electronic remote connection. The required training must provide for  
72.23 competency testing. Personal care assistance provider agency billing staff shall complete  
72.24 training about personal care assistance program financial management. This training is  
72.25 effective July 1, 2009. Any personal care assistance provider agency enrolled before that  
72.26 date shall, if it has not already, complete the provider training within 18 months of July 1,  
72.27 2009. Any new owners or employees in management and supervisory positions involved  
72.28 in the day-to-day operations are required to complete mandatory training as a requisite of  
72.29 working for the agency. Personal care assistance provider agencies certified for participation  
72.30 in Medicare as home health agencies are exempt from the training required in this  
72.31 subdivision. When available, Medicare-certified home health agency owners, supervisors,  
72.32 or managers must successfully complete the competency test.

72.33 (d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability  
72.34 insurance required by this subdivision must be maintained continuously and purchased new  
72.35 annually. After initial enrollment, a provider must submit proof of bonds and required

73.1 coverages at any time at the request of the commissioner. Services provided while there are  
73.2 lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions,  
73.3 including termination. The commissioner shall send instructions and a due date to submit  
73.4 the requested information to the personal care assistance provider agency.

73.5 Sec. 12. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is  
73.6 amended to read:

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

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

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

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

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

73.17 (5) provides at the time of enrollment, reenrollment, and revalidation in a format  
73.18 determined by the commissioner, proof of surety bond coverage for each business location  
73.19 providing services. Upon new enrollment, or if the provider's medical assistance revenue  
73.20 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety  
73.21 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over  
73.22 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond  
73.23 must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually,  
73.24 and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action  
73.25 to obtain monetary recovery or sanctions from a surety bond must occur within six years  
73.26 from the date the debt is affirmed by a final agency decision. An agency decision is final  
73.27 when the right to appeal the debt has been exhausted or the time to appeal has expired under  
73.28 section 256B.064;

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

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

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

74.1 Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 12, is amended  
74.2 to read:

74.3 Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS  
74.4 agency-providers must provide, at the time of enrollment, reenrollment, and revalidation  
74.5 as a CFSS agency-provider in a format determined by the commissioner, information and  
74.6 documentation that includes but is not limited to the following:

74.7 (1) the CFSS agency-provider's current contact information including address, telephone  
74.8 number, and email address;

74.9 (2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's  
74.10 Medicaid revenue in the previous calendar year is less than or equal to \$300,000, the  
74.11 agency-provider must purchase a surety bond of \$50,000. If the agency-provider's Medicaid  
74.12 revenue in the previous calendar year is greater than \$300,000, the agency-provider must  
74.13 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the  
74.14 commissioner, must be ~~renewed~~ purchased new annually, and must allow for recovery of  
74.15 costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or  
74.16 sanctions from a surety bond must occur within six years from the date the debt is affirmed  
74.17 by a final agency decision. An agency decision is final when the right to appeal the debt  
74.18 has been exhausted or the time to appeal has expired under section 256B.064;

74.19 (3) proof of fidelity bond coverage in the amount of \$20,000 per provider location;

74.20 (4) proof of workers' compensation insurance coverage;

74.21 (5) proof of liability insurance;

74.22 (6) a copy of the CFSS agency-provider's organizational chart identifying the names  
74.23 and roles of all owners, managing employees, staff, board of directors, and additional  
74.24 documentation reporting any affiliations of the directors and owners to other service  
74.25 providers;

74.26 (7) proof that the CFSS agency-provider has written policies and procedures including:  
74.27 hiring of employees; training requirements; service delivery; and employee and consumer  
74.28 safety, including the process for notification and resolution of participant grievances, incident  
74.29 response, identification and prevention of communicable diseases, and employee misconduct;

74.30 (8) proof that the CFSS agency-provider has all of the following forms and documents:

74.31 (i) a copy of the CFSS agency-provider's time sheet; and

74.32 (ii) a copy of the participant's individual CFSS service delivery plan;

75.1 (9) a list of all training and classes that the CFSS agency-provider requires of its staff  
75.2 providing CFSS services;

75.3 (10) documentation that the CFSS agency-provider and staff have successfully completed  
75.4 all the training required by this section;

75.5 (11) documentation of the agency-provider's marketing practices;

75.6 (12) disclosure of ownership, leasing, or management of all residential properties that  
75.7 are used or could be used for providing home care services;

75.8 (13) documentation that the agency-provider will use at least the following percentages  
75.9 of revenue generated from the medical assistance rate paid for CFSS services for CFSS  
75.10 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except  
75.11 100 percent of the revenue generated by a medical assistance rate increase due to a collective  
75.12 bargaining agreement under section 179A.54 must be used for support worker wages and  
75.13 benefits. The revenue generated by the worker training and development services and the  
75.14 reasonable costs associated with the worker training and development services shall not be  
75.15 used in making this calculation; and

75.16 (14) documentation that the agency-provider does not burden participants' free exercise  
75.17 of their right to choose service providers by requiring CFSS support workers to sign an  
75.18 agreement not to work with any particular CFSS participant or for another CFSS  
75.19 agency-provider after leaving the agency and that the agency is not taking action on any  
75.20 such agreements or requirements regardless of the date signed.

75.21 (b) CFSS agency-providers shall provide to the commissioner the information specified  
75.22 in paragraph (a).

75.23 (c) All CFSS agency-providers shall require all employees in management and  
75.24 supervisory positions and owners of the agency who are active in the day-to-day management  
75.25 and operations of the agency to complete mandatory training as determined by the  
75.26 commissioner. Employees in management and supervisory positions and owners who are  
75.27 active in the day-to-day operations of an agency who have completed the required training  
75.28 as an employee with a CFSS agency-provider do not need to repeat the required training if  
75.29 they are hired by another agency and they have completed the training within the past three  
75.30 years. CFSS agency-provider billing staff shall complete training about CFSS program  
75.31 financial management. Any new owners or employees in management and supervisory  
75.32 positions involved in the day-to-day operations are required to complete mandatory training  
75.33 as a requisite of working for the agency.

76.1 (d) Agency-providers shall submit all required documentation in this section within 30  
76.2 days of notification from the commissioner. If an agency-provider fails to submit all the  
76.3 required documentation, the commissioner may take action under subdivision 23a.

76.4 Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 17a, is  
76.5 amended to read:

76.6 Subd. 17a. **Consultation services provider qualifications and**  
76.7 **requirements.** Consultation services providers must meet the following qualifications and  
76.8 requirements:

76.9 (1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4)  
76.10 and (5);

76.11 (2) be under contract with the department and enrolled as a Minnesota health care program  
76.12 provider;

76.13 (3) not be the FMS provider, the lead agency, or the CFSS or home and community-based  
76.14 services waiver vendor or agency-provider to the participant;

76.15 (4) meet the service standards as established by the commissioner;

76.16 (5) have proof of surety bond coverage. Upon new enrollment, or if the consultation  
76.17 service provider's Medicaid revenue in the previous calendar year is less than or equal to  
76.18 \$300,000, the consultation service provider must purchase a surety bond of \$50,000. If the  
76.19 agency-provider's Medicaid revenue in the previous calendar year is greater than \$300,000,  
76.20 the consultation service provider must purchase a surety bond of \$100,000. The surety bond  
76.21 must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually,  
76.22 and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action  
76.23 to obtain monetary recovery or sanctions from a surety bond must occur within six years  
76.24 from the date the debt is affirmed by a final agency decision. An agency decision is final  
76.25 when the right to appeal the debt has been exhausted or the time to appeal has expired under  
76.26 section 256B.064;

76.27 (6) employ lead professional staff with a minimum of two years of experience in  
76.28 providing services such as support planning, support broker, case management or care  
76.29 coordination, or consultation services and consumer education to participants using a  
76.30 self-directed program using FMS under medical assistance;

76.31 (7) report maltreatment as required under chapter 260E and section 626.557;

76.32 (8) comply with medical assistance provider requirements;

77.1 (9) understand the CFSS program and its policies;

77.2 (10) be knowledgeable about self-directed principles and the application of the  
77.3 person-centered planning process;

77.4 (11) have general knowledge of the FMS provider duties and the vendor fiscal/employer  
77.5 agent model, including all applicable federal, state, and local laws and regulations regarding  
77.6 tax, labor, employment, and liability and workers' compensation coverage for household  
77.7 workers; and

77.8 (12) have all employees, including lead professional staff, staff in management and  
77.9 supervisory positions, and owners of the agency who are active in the day-to-day management  
77.10 and operations of the agency, complete training as specified in the contract with the  
77.11 department.

77.12 Sec. 15. **REPEALER.**

77.13 Minnesota Statutes 2025 Supplement, sections 245A.042, subdivision 5; and 245A.10,  
77.14 subdivision 3a, are repealed.

77.15 **EFFECTIVE DATE.** This section is effective October 1, 2026.

77.16 **ARTICLE 3**  
77.17 **BACKGROUND STUDIES**

77.18 Section 1. Minnesota Statutes 2024, section 245C.03, subdivision 3a, is amended to read:

77.19 Subd. 3a. **Personal care assistance provider agency; background studies.** Personal  
77.20 care assistance provider agencies enrolled to provide personal care assistance services under  
77.21 the medical assistance program must meet the following requirements:

77.22 (1) owners who have a five percent interest or more, board members, and all managing  
77.23 employees are subject to a background study as provided in this chapter. This requirement  
77.24 applies to currently enrolled personal care assistance provider agencies and agencies seeking  
77.25 enrollment as a personal care assistance provider agency. "Managing employee" has the  
77.26 same meaning as in Code of Federal Regulations, title 42, section 455.101. An organization  
77.27 is barred from enrollment if:

77.28 (i) the organization has not initiated background studies of owners and managing  
77.29 employees; or

77.30 (ii) the organization has initiated background studies of owners and managing employees  
77.31 and the commissioner has sent the organization a notice that an owner or managing employee

78.1 of the organization has been disqualified under section 245C.14, and the owner or managing  
78.2 employee has not received a set aside of the disqualification under section 245C.22; and

78.3 (2) a background study must be initiated and completed for all employee and volunteer  
78.4 qualified professionals.

78.5 **EFFECTIVE DATE.** This section is effective September 15, 2026.

78.6 Sec. 2. Minnesota Statutes 2024, section 245C.03, subdivision 9, is amended to read:

78.7 Subd. 9. **Community first services and supports and financial management services**  
78.8 **organizations.** Individuals affiliated with Community First Services and Supports (CFSS)  
78.9 agency-providers and Financial Management Services (FMS) providers enrolled to provide  
78.10 CFSS services under the medical assistance program must meet the following requirements:

78.11 (1) owners who have a five percent interest or more, board members, and all managing  
78.12 employees are subject to a background study under this chapter. This requirement applies  
78.13 to currently enrolled providers and agencies seeking enrollment. "Managing employee" has  
78.14 the meaning given in Code of Federal Regulations, title 42, section 455.101. An organization  
78.15 is barred from enrollment if:

78.16 (i) the organization has not initiated background studies of owners and managing  
78.17 employees; or

78.18 (ii) the organization has initiated background studies of owners and managing employees  
78.19 and the commissioner has sent the organization a notice that an owner or managing employee  
78.20 of the organization has been disqualified under section 245C.14 and the owner or managing  
78.21 employee has not received a set aside of the disqualification under section 245C.22;

78.22 (2) a background study must be initiated and completed for all staff employees or  
78.23 volunteers who will have direct contact with the participant to provide worker training and  
78.24 development; and

78.25 (3) a background study must be initiated and completed for all employee and volunteer  
78.26 support workers.

78.27 **EFFECTIVE DATE.** This section is effective September 15, 2026.

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

78.30 **Subd. 17. Providers of adult rehabilitative mental health services.** The commissioner  
78.31 must conduct background studies on any individual who is an owner with an ownership

79.1 stake of at least five percent in an adult rehabilitative mental health services provider, an  
79.2 operator of an adult rehabilitative mental health services provider, or an employee or  
79.3 volunteer who has direct contact with people receiving adult rehabilitative mental health  
79.4 services under section 256B.0623. For purposes of this subdivision, operator includes board  
79.5 members or other individuals who oversee the billing, management, or policies of the  
79.6 services provided.

79.7 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,  
79.8 but no sooner than October 13, 2026.

79.9 Sec. 4. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to  
79.10 read:

79.11 Subd. 18. **Providers of peer recovery services.** The commissioner must conduct  
79.12 background studies on any individual who is an owner with an ownership stake of at least  
79.13 five percent in a peer recovery services provider, an operator of a peer recovery services  
79.14 provider, or an employee or volunteer who has direct contact with people receiving peer  
79.15 recovery services under section 254B.052. For purposes of this subdivision, "operator"  
79.16 includes board members or other individuals who oversee the billing, management, or  
79.17 policies of the services provided.

79.18 Sec. 5. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to  
79.19 read:

79.20 Subd. 19. **Providers of adult assertive community treatment services.** The  
79.21 commissioner must conduct background studies on any individual who is an owner with  
79.22 an ownership stake of at least five percent in an adult assertive community treatment services  
79.23 provider, an operator of an adult assertive community treatment services provider, or an  
79.24 employee or volunteer who has direct contact with people receiving adult assertive  
79.25 community treatment services under section 256B.0622. For purposes of this subdivision,  
79.26 "operator" includes board members or other individuals who oversee the billing, management,  
79.27 or policies of the services provided.

79.28 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,  
79.29 but no sooner than February 16, 2027.

80.1 Sec. 6. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended  
80.2 to read:

80.3 Subd. 2. **Activities pending completion of background study.** The subject of a  
80.4 background study may not perform any activity requiring a background study under  
80.5 paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

80.6 (a) Notices from the commissioner required prior to activity under paragraph (c) include:

80.7 (1) a notice of the study results under section 245C.17 stating that:

80.8 (i) the individual is not disqualified; or

80.9 (ii) more time is needed to complete the study but the individual is not required to be  
80.10 removed from direct contact or access to people receiving services prior to completion of  
80.11 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice  
80.12 that more time is needed to complete the study must also indicate whether the individual is  
80.13 required to be under continuous direct supervision prior to completion of the background  
80.14 study. When more time is necessary to complete a background study of an individual  
80.15 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,  
80.16 the individual may not work in the facility or setting regardless of whether or not the  
80.17 individual is supervised;

80.18 (2) a notice that a disqualification has been set aside under section 245C.23; or

80.19 (3) a notice that a variance has been granted related to the individual under section  
80.20 245C.30.

80.21 (b) For a background study affiliated with a licensed child care center or certified  
80.22 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),  
80.23 must not be issued until the commissioner receives a qualifying result for the individual for  
80.24 the fingerprint-based national criminal history record check or the fingerprint-based criminal  
80.25 history information from the Bureau of Criminal Apprehension. The notice must require  
80.26 the individual to be under continuous direct supervision prior to completion of the remainder  
80.27 of the background study except as permitted in subdivision 3.

80.28 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

80.29 (1) being issued a license;

80.30 (2) living in the household where the licensed program will be provided;

80.31 (3) providing direct contact services to persons served by a program unless the subject  
80.32 is under continuous direct supervision;

81.1 (4) having access to persons receiving services if the background study was completed  
81.2 under section 144.057, subdivision 1, or 245C.03, ~~subdivision 1, paragraph (a), clause (2),~~  
81.3 ~~(5), or (6)~~; unless the subject is under continuous direct supervision;

81.4 (5) for licensed child care centers and certified license-exempt child care centers,  
81.5 providing direct contact services to persons served by the program;

81.6 (6) for children's residential facilities or foster residence settings, working in the facility  
81.7 or setting; or

81.8 (7) for background studies affiliated with a personal care provider organization, ~~except~~  
81.9 ~~as provided in section 245C.03, subdivision 3b,~~ early intensive developmental and behavioral  
81.10 intervention provider, housing support or supplementary services provider, special  
81.11 transportation services provider, or community first services and supports provider before  
81.12 ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider~~  
81.13 ~~agency entity~~ must initiate a background study of the ~~personal care assistant~~ individual  
81.14 under this chapter and the ~~personal care assistance provider agency entity~~ must have received  
81.15 a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

81.17 (ii) disqualified, but the ~~personal care assistant~~ individual has received a set aside of the  
81.18 disqualification under section 245C.22; ~~or.~~

81.19 ~~(8) for background studies affiliated with an early intensive developmental and behavioral~~  
81.20 ~~intervention provider, before an individual provides services, the early intensive~~  
81.21 ~~developmental and behavioral intervention provider must initiate a background study for~~  
81.22 ~~the individual under this chapter and the early intensive developmental and behavioral~~  
81.23 ~~intervention provider must have received a notice from the commissioner that the individual~~  
81.24 ~~is:~~

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

81.26 ~~(ii) disqualified, but the individual has received a set aside of the disqualification under~~  
81.27 ~~section 245C.22.~~

81.28 **EFFECTIVE DATE.** This section is effective September 15, 2026.

81.29 Sec. 7. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended  
81.30 to read:

81.31 Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines  
81.32 that the individual studied has a disqualifying characteristic, the commissioner shall review

82.1 the information immediately available and make a determination as to the subject's immediate  
82.2 risk of harm to persons served by the program where the individual studied will have direct  
82.3 contact with, or access to, people receiving services.

82.4 (b) The commissioner shall consider all relevant information available, including the  
82.5 following factors in determining the immediate risk of harm:

82.6 (1) the recency of the disqualifying characteristic;

82.7 (2) the recency of discharge from probation for the crimes;

82.8 (3) the number of disqualifying characteristics;

82.9 (4) the intrusiveness or violence of the disqualifying characteristic;

82.10 (5) the vulnerability of the victim involved in the disqualifying characteristic;

82.11 (6) the similarity of the victim to the persons served by the program where the individual  
82.12 studied will have direct contact;

82.13 (7) whether the individual has a disqualification from a previous background study that  
82.14 has not been set aside;

82.15 (8) if the individual has a disqualification which may not be set aside because it is a  
82.16 permanent bar under section 245C.24, subdivision 1, or the individual is a child care  
82.17 background study subject who has a felony-level conviction for a drug-related offense in  
82.18 the last five years, the commissioner may order the immediate removal of the individual  
82.19 from any position allowing direct contact with, or access to, persons receiving services from  
82.20 the program and from working in a children's residential facility or foster residence setting;  
82.21 and

82.22 (9) if the individual has a disqualification which may not be set aside because it is a  
82.23 permanent bar under section 245C.24, subdivision 2, or the individual is a child care  
82.24 background study subject who has a felony-level conviction for a drug-related offense during  
82.25 the last five years, the commissioner may order the immediate removal of the individual  
82.26 from any position allowing direct contact with or access to persons receiving services from  
82.27 the center and from working in a licensed child care center or certified license-exempt child  
82.28 care center.

82.29 (c) This section does not apply when the subject of a background study is regulated by  
82.30 a health-related licensing board as defined in chapter 214, and the subject is determined to  
82.31 be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

83.1 (d) This section does not apply to a background study related to an initial application  
83.2 for a child foster family setting license.

83.3 (e) Except for paragraph (f), this section does not apply to a background study that is  
83.4 also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a~~  
83.5 ~~personal care assistant or a qualified professional as defined in section 256B.0659,~~  
83.6 ~~subdivision 1, or to a background study for an individual providing early intensive~~  
83.7 ~~developmental and behavioral intervention services under section 256B.0949 245C.13,~~  
83.8 ~~subdivision 2, paragraph (c), clause (7).~~

83.9 (f) If the commissioner has reason to believe, based on arrest information or an active  
83.10 maltreatment investigation, that an individual poses an imminent risk of harm to persons  
83.11 receiving services, the commissioner may order that the person be continuously supervised  
83.12 or immediately removed pending the conclusion of the maltreatment investigation or criminal  
83.13 proceedings.

83.14 **EFFECTIVE DATE.** This section is effective September 15, 2026.

#### 83.15 ARTICLE 4

#### 83.16 UNIFORM SERVICE STANDARDS

83.17 Section 1. Minnesota Statutes 2024, section 245.735, subdivision 6, is amended to read:

83.18 Subd. 6. **Section 223 of the Protecting Access to Medicare Act entities.** ~~(a) The~~  
83.19 ~~commissioner must request federal approval to participate in the demonstration program~~  
83.20 ~~established by section 223 of the Protecting Access to Medicare Act and, if approved, to~~  
83.21 ~~continue to participate in the demonstration program as long as federal funding for the~~  
83.22 ~~demonstration program remains available from the United States Department of Health and~~  
83.23 ~~Human Services. To the extent practicable, the commissioner shall align the requirements~~  
83.24 ~~of the demonstration program with the requirements under this section for CCBHCs receiving~~  
83.25 ~~medical assistance reimbursement under the authority of the state's Medicaid state plan. A~~  
83.26 ~~CCBHC may not apply to participate as a billing provider in both the CCBHC federal~~  
83.27 ~~demonstration and the benefit for CCBHCs under the medical assistance program.~~

83.28 ~~(b) The commissioner must follow federal payment guidance, including payment of the~~  
83.29 ~~CCBHC daily bundled rate for services rendered by CCBHCs to individuals who are dually~~  
83.30 ~~eligible for Medicare and medical assistance when Medicare is the primary payer for the~~  
83.31 ~~service. Services provided by a CCBHC operating under the authority of the state's Medicaid~~  
83.32 ~~state plan will not receive the prospective payment system rate for services rendered by~~

84.1 ~~CCBHCs to individuals who are dually eligible for Medicare and medical assistance when~~  
84.2 ~~Medicare is the primary payer for the service.~~

84.3 (e) Payment for services rendered by CCBHCs to individuals who have commercial  
84.4 insurance as the primary payer and medical assistance as secondary payer is subject to the  
84.5 requirements under section 256B.37. Services provided by a CCBHC operating under the  
84.6 authority of the 223 demonstration or the state's Medicaid state plan will not receive the  
84.7 prospective payment system rate for services rendered by CCBHCs to individuals who have  
84.8 commercial insurance as the primary payer and medical assistance as the secondary payer.

84.9 Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended  
84.10 to read:

84.11 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

84.12 (1) residential or nonresidential programs that are provided to a person by an individual  
84.13 who is related;

84.14 (2) nonresidential programs that are provided by an unrelated individual to persons from  
84.15 a single related family;

84.16 (3) residential or nonresidential programs that are provided to adults who do not misuse  
84.17 substances or have a substance use disorder, a mental illness, a developmental disability, a  
84.18 functional impairment, or a physical disability;

84.19 (4) sheltered workshops or work activity programs that are certified by the commissioner  
84.20 of employment and economic development;

84.21 (5) programs operated by a public school for children 33 months or older;

84.22 (6) nonresidential programs primarily for children that provide care or supervision for  
84.23 periods of less than three hours a day while the child's parent or legal guardian is in the  
84.24 same building as the nonresidential program or present within another building that is  
84.25 directly contiguous to the building in which the nonresidential program is located;

84.26 (7) nursing homes or hospitals licensed by the commissioner of health except as specified  
84.27 under section 245A.02;

84.28 (8) board and lodge facilities licensed by the commissioner of health that do not provide  
84.29 children's residential services under Minnesota Rules, chapter 2960, mental health or  
84.30 substance use disorder treatment;

84.31 (9) programs licensed by the commissioner of corrections;

- 85.1 (10) recreation programs for children or adults that are operated or approved by a park  
85.2 and recreation board whose primary purpose is to provide social and recreational activities;
- 85.3 (11) noncertified boarding care homes unless they provide services for five or more  
85.4 persons whose primary diagnosis is mental illness or a developmental disability;
- 85.5 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art  
85.6 programs, and nonresidential programs for children provided for a cumulative total of less  
85.7 than 30 days in any 12-month period;
- 85.8 (13) residential programs for persons with mental illness, that are located in hospitals;
- 85.9 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter  
85.10 4630;
- 85.11 (15) mental health outpatient services for adults with mental illness or children with  
85.12 mental illness, except, effective January 1, 2028, for programs licensed under section  
85.13 245A.044;
- 85.14 (16) residential programs serving school-age children whose sole purpose is cultural or  
85.15 educational exchange, until the commissioner adopts appropriate rules;
- 85.16 (17) community support services programs as defined in section 245.462, subdivision  
85.17 6, and family community support services as defined in section 245.4871, subdivision 17;
- 85.18 (18) assisted living facilities licensed by the commissioner of health under chapter 144G;
- 85.19 (19) substance use disorder treatment activities of licensed professionals in private  
85.20 practice as defined in section 245G.01, subdivision 17;
- 85.21 (20) consumer-directed community support service funded under the Medicaid waiver  
85.22 for persons with developmental disabilities when the individual who provided the service  
85.23 is:
- 85.24 (i) the same individual who is the direct payee of these specific waiver funds or paid by  
85.25 a fiscal agent, fiscal intermediary, or employer of record; and
- 85.26 (ii) not otherwise under the control of a residential or nonresidential program that is  
85.27 required to be licensed under this chapter when providing the service;
- 85.28 (21) a county that is an eligible vendor under section 254B.0501 to provide care  
85.29 coordination and comprehensive assessment services;
- 85.30 (22) a recovery community organization that is an eligible vendor under section  
85.31 254B.0501 to provide peer recovery support services; or

86.1 (23) programs licensed by the commissioner of children, youth, and families in chapter  
86.2 142B.

86.3 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a  
86.4 building in which a nonresidential program is located if it shares a common wall with the  
86.5 building in which the nonresidential program is located or is attached to that building by  
86.6 skyway, tunnel, atrium, or common roof.

86.7 (c) Except for the home and community-based services identified in section 245D.03,  
86.8 subdivision 1, nothing in this chapter shall be construed to require licensure for any services  
86.9 provided and funded according to an approved federal waiver plan where licensure is  
86.10 specifically identified as not being a condition for the services and funding.

86.11 **EFFECTIVE DATE.** This section is effective January 1, 2028.

86.12 Sec. 3. **[245A.044] LICENSED NONRESIDENTIAL BEHAVIORAL HEALTH**  
86.13 **SERVICES.**

86.14 **Subdivision 1. License required for certain nonresidential behavioral health**  
86.15 **services.** (a) Beginning January 1, 2028, providers of nonresidential mental health and  
86.16 **substance use disorder services must obtain a license under this chapter to provide:**

86.17 **(1) adult rehabilitative mental health services under section 245I.22;**

86.18 **(2) children's therapeutic services and supports in the community under section 245I.30**  
86.19 **and children's day treatment under section 245I.31;**

86.20 **(3) crisis response services under section 245I.24; and**

86.21 **(4) certified community behavioral health clinic services under section 245I.17.**

86.22 (b) **As a condition of licensure, an applicant or license holder must demonstrate and**  
86.23 **maintain verification of compliance with:**

86.24 **(1) licensing requirements under this chapter and chapter 245I; and**

86.25 **(2) applicable health care program requirements under Minnesota Rules, parts 9505.0170**  
86.26 **to 9505.0475 and 9505.2160 to 9505.2245.**

86.27 **Subd. 2. Implementation.** (a) **Beginning July 1, 2027, the commissioner must begin**  
86.28 **issuing licenses to providers listed in subdivision 1. The commissioner must transition**  
86.29 **providers certified under section 245I.011 and listed in subdivision 1 into licensure with a**  
86.30 **phased-in schedule determined by the commissioner. The commissioner must communicate**

87.1 the implementation schedule to providers at least three months before the application is  
87.2 made available.

87.3 (b) Applicants for licensure must have an approved certification under section 245I.011  
87.4 at least 90 days before the date of the licensure application.

87.5 (c) A provider's certification under section 245I.011, subdivision 5, paragraph (a), clauses  
87.6 (2) to (4), or 6, paragraph (b), expires when the commissioner issues a decision on the  
87.7 provider's license application.

87.8 (d) Upon licensure, a license holder must notify clients and staff of policies and  
87.9 procedures outlined in the application.

87.10 (e) Notwithstanding paragraphs (a) and (c), subdivision 1, and sections 245I.17, 245I.22,  
87.11 245I.24, 245I.30, and 245I.31, a provider listed under subdivision 1, paragraph (a), clauses  
87.12 (1) to (4), and certified under section 245I.011 may continue operating past January 1, 2028,  
87.13 until the commissioner issues a licensing decision if the provider submitted an application  
87.14 before January 1, 2028.

87.15 (f) If a provider fails to submit an application for licensure within the time frame in  
87.16 paragraph (b), the commissioner must disenroll the provider from reimbursement for the  
87.17 following services:

87.18 (1) adult rehabilitative mental health services under section 256B.0623;

87.19 (2) crisis response services under section 256B.0624;

87.20 (3) children's therapeutic services and supports under section 256B.0943; and

87.21 (4) certified community behavioral health clinics under section 256B.0625, subdivision  
87.22 5m.

87.23 (g) The commissioner must disenroll a provider listed in paragraph (f) from medical  
87.24 assistance if:

87.25 (1) the provider's licensing application has been denied or the license has been suspended  
87.26 or revoked; and

87.27 (2) the provider appealed the application denial or the license suspension or revocation,  
87.28 and the commissioner issued a final order on the appeal affirming the action.

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

88.1 Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3, is amended  
88.2 to read:

88.3 Subd. 3. **Application fee for initial license or certification.** (a) Except as provided in  
88.4 paragraphs (c) ~~and~~, (d), and (f), for fees required under subdivision 1, an applicant for an  
88.5 initial license or certification issued by the commissioner shall submit a \$2,100 application  
88.6 fee with each new application required under this subdivision. The application fee shall not  
88.7 be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that  
88.8 expires on December 31. The commissioner shall not process an application until the  
88.9 application fee is paid.

88.10 (b) Except as provided in paragraph (c), an applicant shall apply for a license to provide  
88.11 services at a specific location.

88.12 (c) For a license to provide home and community-based services to persons with  
88.13 disabilities or age 65 and older under chapter 245D, an applicant shall submit an application  
88.14 to provide services statewide. For fees required under subdivision 1, an applicant for an  
88.15 initial license issued by the commissioner to provide home and community-based services  
88.16 under chapter 245D shall submit a \$4,200 application fee with each new application.

88.17 (d) For fees required under subdivision 1, an applicant for an initial license or certification  
88.18 issued by the commissioner for children's residential facility ~~or mental health clinic licensure~~  
88.19 ~~or certification~~ shall submit a \$500 application fee with each new application required under  
88.20 this subdivision.

88.21 (e) For fees required under subdivision 1, an applicant for an initial mental health clinic  
88.22 certification issued by the commissioner shall submit a \$2,100 application fee with each  
88.23 new application required under this subdivision.

88.24 (f) For fees required under subdivision 1, an applicant for an initial license issued by  
88.25 the commissioner to provide services at a certified community behavioral health clinic under  
88.26 section 245I.17 shall submit a \$4,200 application fee with each new application.

88.27 Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended  
88.28 to read:

88.29 Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed  
88.30 to provide one or more of the home and community-based services and supports identified  
88.31 under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual  
88.32 nonrefundable license fee based on revenues derived from the provision of services that

89.1 would require licensure under chapter 245D during the calendar year immediately preceding  
89.2 the year in which the license fee is paid, according to the following schedule:

89.3	License Holder Annual Revenue	License Fee
89.4	less than or equal to \$10,000	\$250
89.5	greater than \$10,000 but less than or	
89.6	equal to \$25,000	\$375
89.7	greater than \$25,000 but less than or	
89.8	equal to \$50,000	\$500
89.9	greater than \$50,000 but less than or	
89.10	equal to \$100,000	\$625
89.11	greater than \$100,000 but less than or	
89.12	equal to \$150,000	\$750
89.13	greater than \$150,000 but less than or	
89.14	equal to \$200,000	\$1,000
89.15	greater than \$200,000 but less than or	
89.16	equal to \$250,000	\$1,250
89.17	greater than \$250,000 but less than or	
89.18	equal to \$300,000	\$1,500
89.19	greater than \$300,000 but less than or	
89.20	equal to \$350,000	\$1,750
89.21	greater than \$350,000 but less than or	
89.22	equal to \$400,000	\$2,000
89.23	greater than \$400,000 but less than or	
89.24	equal to \$450,000	\$2,250
89.25	greater than \$450,000 but less than or	
89.26	equal to \$500,000	\$2,500
89.27	greater than \$500,000 but less than or	
89.28	equal to \$600,000	\$2,850
89.29	greater than \$600,000 but less than or	
89.30	equal to \$700,000	\$3,200
89.31	greater than \$700,000 but less than or	
89.32	equal to \$800,000	\$3,600
89.33	greater than \$800,000 but less than or	
89.34	equal to \$900,000	\$3,900
89.35	greater than \$900,000 but less than or	
89.36	equal to \$1,000,000	\$4,250
89.37	greater than \$1,000,000 but less than or	
89.38	equal to \$1,250,000	\$4,550
89.39	greater than \$1,250,000 but less than or	
89.40	equal to \$1,500,000	\$4,900
89.41	greater than \$1,500,000 but less than or	
89.42	equal to \$1,750,000	\$5,200
89.43	greater than \$1,750,000 but less than or	
89.44	equal to \$2,000,000	\$5,500

90.1	greater than \$2,000,000 but less than or	
90.2	equal to \$2,500,000	\$5,900
90.3	greater than \$2,500,000 but less than or	
90.4	equal to \$3,000,000	\$6,200
90.5	greater than \$3,000,000 but less than or	
90.6	equal to \$3,500,000	\$6,500
90.7	greater than \$3,500,000 but less than or	
90.8	equal to \$4,000,000	\$7,200
90.9	greater than \$4,000,000 but less than or	
90.10	equal to \$4,500,000	\$7,800
90.11	greater than \$4,500,000 but less than or	
90.12	equal to \$5,000,000	\$9,000
90.13	greater than \$5,000,000 but less than or	
90.14	equal to \$7,500,000	\$10,000
90.15	greater than \$7,500,000 but less than or	
90.16	equal to \$10,000,000	\$14,000
90.17	greater than \$10,000,000 but less than or	
90.18	equal to \$12,500,000	\$18,000
90.19	greater than \$12,500,000 but less than or	
90.20	equal to \$15,000,000	\$25,000
90.21	greater than \$15,000,000 but less than or	
90.22	equal to \$17,500,000	\$28,000
90.23	greater than \$17,500,000 but less than	
90.24	\$20,000,000	\$32,000
90.25	greater than \$20,000,000 but less than	
90.26	\$25,000,000	\$36,000
90.27	greater than \$25,000,000 but less than	
90.28	\$30,000,000	\$45,000
90.29	greater than \$30,000,000 but less than	
90.30	\$35,000,000	\$55,000
90.31	greater than \$35,000,000	\$75,000

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

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

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

91.1 (b) A substance use disorder treatment program licensed under chapter 245G, to provide  
91.2 substance use disorder treatment shall pay an annual nonrefundable license fee based on  
91.3 the following schedule:

91.4	Licensed Capacity	License Fee
91.5	1 to 24 persons	\$2,600
91.6	25 to 49 persons	\$3,000
91.7	50 to 74 persons	\$5,000
91.8	75 to 99 persons	\$10,000
91.9	100 to 199 persons	\$15,000
91.10	200 or more persons	\$20,000

91.11 (c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to  
91.12 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay  
91.13 an annual nonrefundable license fee based on the following schedule:

91.14	Licensed Capacity	License Fee
91.15	1 to 24 persons	\$2,600
91.16	25 to 49 persons	\$3,000
91.17	50 or more persons	\$5,000

91.18 A detoxification program that also operates a withdrawal management program at the same  
91.19 location shall only pay one fee based upon the licensed capacity of the program with the  
91.20 higher overall capacity.

91.21 (d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to  
91.22 serve children shall pay an annual nonrefundable license fee based on the following schedule:

91.23	Licensed Capacity	License Fee
91.24	1 to 24 persons	\$1,000
91.25	25 to 49 persons	\$1,100
91.26	50 to 74 persons	\$1,200
91.27	75 to 99 persons	\$1,300
91.28	100 or more persons	\$1,400

91.29 (e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts  
91.30 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual  
91.31 nonrefundable license fee based on the following schedule:

91.32	Licensed Capacity	License Fee
91.33	1 to 24 persons	\$2,600

92.1	25 to 49 persons	\$3,000
92.2	50 or more persons	\$20,000

92.3 (f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,  
92.4 to serve persons with physical disabilities shall pay an annual nonrefundable license fee  
92.5 based on the following schedule:

92.6	Licensed Capacity	License Fee
92.7	1 to 24 persons	\$450
92.8	25 to 49 persons	\$650
92.9	50 to 74 persons	\$850
92.10	75 to 99 persons	\$1,050
92.11	100 or more persons	\$1,250

92.12 (g) A program licensed as an adult day care center licensed under Minnesota Rules,  
92.13 parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the  
92.14 following schedule:

92.15	Licensed Capacity	License Fee
92.16	1 to 24 persons	\$2,600
92.17	25 to 49 persons	\$3,000
92.18	50 to 74 persons	\$5,000
92.19	75 to 99 persons	\$10,000
92.20	100 to 199 persons	\$15,000
92.21	200 or more persons	\$20,000

92.22 (h) A program licensed to provide treatment services to persons with sexual psychopathic  
92.23 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to  
92.24 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

92.25 (i) A mental health clinic certified under section 245I.20 shall pay an annual  
92.26 nonrefundable certification fee of ~~\$1,550~~ \$3,000. If the mental health clinic provides services  
92.27 at a primary location with satellite facilities, the satellite facilities shall be certified with the  
92.28 primary location without an additional charge.

92.29 ~~(j) If a program subject to annual fees under paragraph (b) provides services at a primary~~  
92.30 ~~location with satellite facilities, the satellite facilities must be licensed with the primary~~  
92.31 ~~location and must be subject to an additional \$500 annual nonrefundable license fee per~~  
92.32 ~~satellite facility.~~

93.1 (j) A program licensed to provide behavioral health treatment services licensed under  
93.2 section 245I.22, 245I.24, 245I.30, or 245I.31 shall pay an annual nonrefundable license fee  
93.3 of \$3,000 for each license.

93.4 (k) Certified community behavioral health clinics licensed under section 245I.17 shall  
93.5 pay an annual nonrefundable license fee of \$7,800.

93.6 Sec. 6. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to  
93.7 read:

93.8 Subd. 4a. Fees for satellite locations. (a) If a program subject to annual fees under  
93.9 subdivision 4, paragraph (b), provides services at a primary location with satellite facilities,  
93.10 the satellite facilities are licensed with the primary location and are subject to an additional  
93.11 \$500 annual nonrefundable license fee per satellite facility.

93.12 (b) If a program subject to annual fees under subdivision 4, paragraph (j), provides  
93.13 services at a primary location with satellite sites or facilities, the satellite locations must be  
93.14 licensed with the primary location and are subject to an additional annual nonrefundable  
93.15 fee according to the following schedule:

93.16 (1) one to five satellite locations: \$1,500;

93.17 (2) six to 19 satellite locations: \$3,500; or

93.18 (3) 20 or more satellite locations: \$5,000.

93.19 Sec. 7. Minnesota Statutes 2024, section 245A.65, subdivision 1a, is amended to read:

93.20 **Subd. 1a. Determination of vulnerable adult status.** (a) A license holder that provides  
93.21 services to adults who are excluded from the definition of vulnerable adult under section  
93.22 626.5572, subdivision 21, paragraph (a), clause (2), must determine whether the person is  
93.23 a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4). This  
93.24 determination must be made within 24 hours of:

93.25 (1) admission to the licensed program; and

93.26 (2) any incident that:

93.27 (i) was reported under section 626.557; or

93.28 (ii) would have been required to be reported under section 626.557, if one or more of  
93.29 the adults involved in the incident had been vulnerable adults.

94.1 (b) Upon determining that a person receiving services is a vulnerable adult under section  
94.2 626.5572, subdivision 21, paragraph (a), clause (4), all requirements relative to vulnerable  
94.3 adults under this chapter and section 626.557 must be met by the license holder.

94.4 (c) Notwithstanding paragraph (a), clause (1), a license holder providing mobile crisis  
94.5 services must make the required determination within 24 hours of first providing crisis  
94.6 stabilization services to an adult under section 245I.24, subdivision 9.

94.7 Sec. 8. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

94.8 Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall  
94.9 conduct a background study on:

94.10 (1) the person or persons applying for a license;

94.11 (2) an individual age 13 and over living in the household where the licensed program  
94.12 will be provided who is not receiving licensed services from the program;

94.13 (3) current or prospective employees of the applicant or license holder who will have  
94.14 direct contact with persons served by the facility, agency, or program;

94.15 (4) volunteers or student volunteers who will have direct contact with persons served  
94.16 by the program to provide program services if the contact is not under the continuous, direct  
94.17 supervision by an individual listed in clause (1) or (3);

94.18 (5) an individual age ten to 12 living in the household where the licensed services will  
94.19 be provided when the commissioner has reasonable cause as defined in section 245C.02,  
94.20 subdivision 15;

94.21 (6) an individual who, without providing direct contact services at a licensed program,  
94.22 may have unsupervised access to children or vulnerable adults receiving services from a  
94.23 program, when the commissioner has reasonable cause as defined in section 245C.02,  
94.24 subdivision 15; and

94.25 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

94.26 (8) notwithstanding clause (3), for children's residential facilities and foster residence  
94.27 settings, any adult working in the facility, whether or not the individual will have direct  
94.28 contact with persons served by the facility.

94.29 (b) For child foster care when the license holder resides in the home where foster care  
94.30 services are provided, a short-term substitute caregiver providing direct contact services for  
94.31 a child for less than 72 hours of continuous care is not required to receive a background  
94.32 study under this chapter.

95.1 (c) This subdivision applies to the following programs that must be licensed under  
95.2 chapter 245A:

95.3 (1) adult foster care;

95.4 (2) children's residential facilities;

95.5 (3) licensed home and community-based services under chapter 245D;

95.6 (4) residential mental health programs for adults;

95.7 (5) substance use disorder treatment programs under chapter 245G;

95.8 (6) withdrawal management programs under chapter 245F;

95.9 (7) adult day care centers;

95.10 (8) family adult day services;

95.11 (9) detoxification programs;

95.12 (10) community residential settings;

95.13 (11) intensive residential treatment services and residential crisis stabilization under  
95.14 chapter 245I; ~~and~~

95.15 (12) treatment programs for persons with sexual psychopathic personality or sexually  
95.16 dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts  
95.17 9515.3000 to 9515.3110;

95.18 (13) adult rehabilitative mental health services under chapter 245I;

95.19 (14) certified community behavioral health clinic services under chapter 245I;

95.20 (15) children's therapeutic services and supports under chapter 245I; and

95.21 (16) crisis response services under chapter 245I.

95.22 Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended  
95.23 to read:

95.24 Subd. 2. **Activities pending completion of background study.** The subject of a  
95.25 background study may not perform any activity requiring a background study under  
95.26 paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

95.27 (a) Notices from the commissioner required prior to activity under paragraph (c) include:

95.28 (1) a notice of the study results under section 245C.17 stating that:

95.29 (i) the individual is not disqualified; or

96.1 (ii) more time is needed to complete the study but the individual is not required to be  
96.2 removed from direct contact or access to people receiving services prior to completion of  
96.3 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice  
96.4 that more time is needed to complete the study must also indicate whether the individual is  
96.5 required to be under continuous direct supervision prior to completion of the background  
96.6 study. When more time is necessary to complete a background study of an individual  
96.7 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,  
96.8 the individual may not work in the facility or setting regardless of whether or not the  
96.9 individual is supervised;

96.10 (2) a notice that a disqualification has been set aside under section 245C.23; or

96.11 (3) a notice that a variance has been granted related to the individual under section  
96.12 245C.30.

96.13 (b) For a background study affiliated with a licensed child care center or certified  
96.14 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),  
96.15 must not be issued until the commissioner receives a qualifying result for the individual for  
96.16 the fingerprint-based national criminal history record check or the fingerprint-based criminal  
96.17 history information from the Bureau of Criminal Apprehension. The notice must require  
96.18 the individual to be under continuous direct supervision prior to completion of the remainder  
96.19 of the background study except as permitted in subdivision 3.

96.20 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

96.21 (1) being issued a license;

96.22 (2) living in the household where the licensed program will be provided;

96.23 (3) providing direct contact services to persons served by a program unless the subject  
96.24 is under continuous direct supervision;

96.25 (4) having access to persons receiving services if the background study was completed  
96.26 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),  
96.27 (5), or (6), unless the subject is under continuous direct supervision;

96.28 (5) for licensed child care centers and certified license-exempt child care centers,  
96.29 providing direct contact services to persons served by the program;

96.30 (6) for children's residential facilities or foster residence settings, working in the facility  
96.31 or setting;

97.1 (7) for background studies affiliated with a personal care provider organization, except  
97.2 as provided in section 245C.03, subdivision 3b, or with an early intensive developmental  
97.3 and behavioral intervention provider or adult rehabilitative mental health services provider,  
97.4 before a ~~personal care assistant~~ an individual provides services, the ~~personal care assistance~~  
97.5 ~~provider agency~~ entity must initiate a background study of the ~~personal care assistant~~  
97.6 individual under this chapter and the ~~personal care assistance provider agency~~ entity must  
97.7 have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

97.9 (ii) disqualified, but the personal care assistant has received a set aside of the  
97.10 disqualification under section 245C.22; or

97.11 (8) for background studies affiliated with an early intensive developmental and behavioral  
97.12 intervention provider, before an individual provides services, the early intensive  
97.13 developmental and behavioral intervention provider must initiate a background study for  
97.14 the individual under this chapter and the early intensive developmental and behavioral  
97.15 intervention provider must have received a notice from the commissioner that the individual  
97.16 is:

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

97.18 (ii) disqualified, but the individual has received a set-aside of the disqualification under  
97.19 section 245C.22.

97.20 Sec. 10. Minnesota Statutes 2024, section 245G.03, subdivision 1, is amended to read:

97.21 Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance  
97.22 use disorder treatment must comply with the general requirements in section 626.557;  
97.23 chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

97.24 (b) The commissioner may grant variances to the requirements in this chapter that do  
97.25 not affect the client's health or safety if the conditions in section 245A.04, subdivision 9,  
97.26 are met.

97.27 (c) If a program is licensed according to this chapter and is part of a certified community  
97.28 behavioral health clinic under section ~~245.735~~ 245I.17, the license holder must comply with  
97.29 the requirements in section ~~245.735~~ 245I.17, subdivisions ~~4b to 4e~~ 12 and 13, as part of the  
97.30 licensing requirements under this chapter.

98.1 Sec. 11. Minnesota Statutes 2024, section 245I.011, subdivision 3, is amended to read:

98.2 Subd. 3. **Certification required.** (a) An individual, organization, or government entity  
98.3 that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause  
98.4 ~~(12)~~ (15), and chooses to be identified as a certified mental health clinic must:

98.5 (1) be a mental health clinic that is certified under section 245I.20;

98.6 (2) comply with all of the responsibilities assigned to a license holder by this chapter  
98.7 except subdivision 1; and

98.8 (3) comply with all of the responsibilities assigned to a certification holder by chapter  
98.9 245A.

98.10 (b) An individual, organization, or government entity described by this subdivision must  
98.11 obtain a criminal background study for each staff person or volunteer who provides direct  
98.12 contact services to clients.

98.13 ~~(c) If a clinic is certified according to this chapter and is part of a certified community~~  
98.14 ~~behavioral health clinic under section 245.735, the license holder must comply with the~~  
98.15 ~~requirements in section 245.735, subdivisions 4b to 4e, as part of the licensing requirements~~  
98.16 ~~under this chapter.~~

98.17 **EFFECTIVE DATE.** This section is effective the day following final enactment, except  
98.18 the amendment striking paragraph (c) is effective January 1, 2028.

98.19 Sec. 12. Minnesota Statutes 2024, section 245I.011, subdivision 5, is amended to read:

98.20 Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or  
98.21 government entity certified under the following sections must comply with all of the  
98.22 responsibilities assigned to a license holder under this chapter except subdivision 1:

98.23 (1) an assertive community treatment provider under section 256B.0622, subdivision  
98.24 3a;

98.25 ~~(2) an adult rehabilitative mental health services provider under section 256B.0623;~~

98.26 ~~(3) a mobile crisis team under section 256B.0624;~~

98.27 ~~(4) a children's therapeutic services and supports provider under section 256B.0943;~~

98.28 ~~(5)~~ (2) a children's intensive behavioral health services provider under section 256B.0946;

98.29 and

98.30 ~~(6)~~ (3) an intensive nonresidential rehabilitative mental health services provider under  
98.31 section 256B.0947.

99.1 (b) An individual, organization, or government entity certified under the sections listed  
99.2 in paragraph (a), ~~clauses (1) to (6)~~, must obtain a criminal background study for each staff  
99.3 person and volunteer providing direct contact services to a client.

99.4 **EFFECTIVE DATE.** This section is effective January 1, 2028.

99.5 Sec. 13. Minnesota Statutes 2024, section 245I.011, is amended by adding a subdivision  
99.6 to read:

99.7 Subd. 6. **License required for nonresidential programs.** (a) Beginning January 1,  
99.8 2028, an individual, organization, or government entity must have a license under this  
99.9 chapter to provide the following services:

99.10 (1) adult rehabilitative mental health services, as defined in section 256B.0623;

99.11 (2) mobile crisis services, as defined in section 256B.0624;

99.12 (3) children's therapeutic services and supports, as defined in section 256B.0943; or

99.13 (4) certified community behavioral health clinic services, as defined in sections 245I.17  
99.14 and 256B.0625, subdivision 5m.

99.15 (b) An individual, organization, or government entity certified as any of the following  
99.16 must remain certified according to subdivision 5 until the commissioner issues a license,  
99.17 the commissioner denies the license application, or the certification expires according to  
99.18 chapter 245A:

99.19 (1) an adult rehabilitative mental health services provider under section 256B.0623;

99.20 (2) a mobile crisis team under section 256B.0624;

99.21 (3) a children's therapeutic services and supports provider under section 256B.0943; or

99.22 (4) a certified community behavioral health clinic under section 245.735.

99.23 Sec. 14. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision  
99.24 to read:

99.25 Subd. 1a. **Alcohol and drug counselor.** "Alcohol and drug counselor" means an  
99.26 individual qualified under section 245G.11, subdivision 5.

100.1 Sec. 15. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision  
100.2 to read:

100.3 Subd. 10a. **Comprehensive evaluation.** "Comprehensive evaluation" means a  
100.4 person-centered, family-centered, and trauma-informed evaluation conducted according to  
100.5 section 245I.17, subdivision 12.

100.6 Sec. 16. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision  
100.7 to read:

100.8 Subd. 18a. **Initial evaluation.** "Initial evaluation" means the assessment and preliminary  
100.9 diagnosis necessary to begin client services, conducted according to section 245I.17.

100.10 Sec. 17. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision  
100.11 to read:

100.12 Subd. 31a. **Psychotherapy.** "Psychotherapy" has the meaning given in section 256B.0671,  
100.13 subdivision 11.

100.14 Sec. 18. Minnesota Statutes 2024, section 245I.02, subdivision 33, is amended to read:

100.15 **Subd. 33. **Rehabilitative mental health services.**** "Rehabilitative mental health services"  
100.16 means mental health services provided to ~~an adult~~ a client that enable the client to develop  
100.17 and achieve psychiatric stability, social competencies, personal and emotional adjustment,  
100.18 independent living skills, family roles, and community skills when symptoms of mental  
100.19 illness has impaired any of the client's abilities in these areas. Rehabilitative mental health  
100.20 services include interventions that allow a client to self-monitor, compensate for, counteract,  
100.21 or replace psychosocial skills deficits or maladaptive skills acquired over the course of a  
100.22 mental illness. For a child client, rehabilitative mental health services include interventions  
100.23 to restore a child or adolescent to an age-appropriate developmental trajectory that has been  
100.24 disrupted by a mental illness.

100.25 Sec. 19. Minnesota Statutes 2024, section 245I.02, subdivision 39, is amended to read:

100.26 **Subd. 39. **Treatment plan.**** "Treatment plan" means services that a license holder  
100.27 formulates to respond to a client's needs and goals. A treatment plan includes individual  
100.28 treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under  
100.29 section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision  
100.30 8, and 256B.0624, subdivision 11. For a license holder under section 245I.17, a treatment

101.1 plan is the integrated treatment plan developed according to section 245I.17, subdivision  
101.2 13.

101.3 Sec. 20. Minnesota Statutes 2024, section 245I.03, subdivision 4, is amended to read:

101.4 Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each  
101.5 staff person follows when responding to a client who exhibits behavior that threatens the  
101.6 immediate safety of the client or others. A license holder's behavioral emergency procedures  
101.7 must incorporate person-centered planning and trauma-informed care.

101.8 (b) A license holder's behavioral emergency procedures must include:

101.9 (1) a plan designed to prevent the client from inflicting self-harm and harming others;

101.10 (2) contact information for emergency resources that a staff person must use when the  
101.11 license holder's behavioral emergency procedures are unsuccessful in controlling a client's  
101.12 behavior;

101.13 (3) the types of behavioral emergency procedures that a staff person may use;

101.14 (4) the specific circumstances under which the program may use behavioral emergency  
101.15 procedures; ~~and~~

101.16 (5) the staff persons whom the license holder authorizes to implement behavioral  
101.17 emergency procedures; and

101.18 (6) the contact information for the local crisis team.

101.19 (c) The license holder's behavioral emergency procedures must not include secluding  
101.20 or restraining a client except as allowed under section 245.8261.

101.21 (d) Staff persons must not use behavioral emergency procedures to enforce program  
101.22 rules or for the convenience of staff persons. Behavioral emergency procedures must not  
101.23 be part of any client's treatment plan. A staff person may not use behavioral emergency  
101.24 procedures except in response to a client's current behavior that threatens the immediate  
101.25 safety of the client or others.

101.26 Sec. 21. Minnesota Statutes 2024, section 245I.03, is amended by adding a subdivision  
101.27 to read:

101.28 Subd. 11. **Quality assurance and improvement plan.** (a) At a minimum, a license  
101.29 holder must develop a written quality assurance and improvement plan that includes plans  
101.30 for:

- 102.1 (1) encouraging ongoing consultation among members of the treatment team;
- 102.2 (2) obtaining and evaluating feedback about services from clients, family and other
- 102.3 natural supports, referral sources, and staff persons;
- 102.4 (3) measuring and evaluating client outcomes;
- 102.5 (4) reviewing client suicide deaths and suicide attempts;
- 102.6 (5) examining the quality of clinical service delivery to clients; and
- 102.7 (6) self-monitoring of compliance with this chapter.
- 102.8 (b) At least annually, a license holder must review, evaluate, and update the quality
- 102.9 assurance and improvement plan. The review must:
- 102.10 (1) include documentation of the actions that the certification holder will take as a result
- 102.11 of information obtained from monitoring activities in the plan; and
- 102.12 (2) establish goals for improved service delivery to clients for the next year.

102.13 Sec. 22. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 5, is amended

102.14 to read:

102.15 Subd. 5. **Behavioral health practitioner scope of practice.** (a) A behavioral health

102.16 practitioner under the treatment supervision of a mental health professional or certified

102.17 rehabilitation specialist may provide an adult client with client education, rehabilitative

102.18 mental health services, functional assessments, level of care assessments, crisis planning,

102.19 and treatment plans. A behavioral health practitioner under the treatment supervision of a

102.20 mental health professional may provide skill-building services ~~to a child client,~~ crisis

102.21 planning, and complete treatment plans for a child client.

102.22 (b) A behavioral health practitioner must not provide treatment supervision to other staff

102.23 persons. A behavioral health practitioner may provide direction to mental health rehabilitation

102.24 workers and mental health behavioral aides.

102.25 (c) A behavioral health practitioner who provides services to clients according to section

102.26 256B.0624 may perform crisis assessments and interventions for a client.

102.27 Sec. 23. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended

102.28 to read:

102.29 Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment

102.30 supervision of a mental health professional, a mental health behavioral aide may ~~practice~~

103.1 ~~psychosocial skills with~~ provide skill-building services to a child client according to the  
103.2 ~~child's treatment plan and individual behavior plan that a mental health professional, clinical~~  
103.3 ~~trainee, or behavioral health practitioner has previously taught to the child.~~

103.4 Sec. 24. Minnesota Statutes 2024, section 245I.06, subdivision 1, is amended to read:

103.5 Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health  
103.6 professional or certified rehabilitation specialist provides treatment supervision to each staff  
103.7 person who provides services to a client and who is not a mental health professional or  
103.8 certified rehabilitation specialist. When providing treatment supervision, a treatment  
103.9 supervisor must follow a staff person's written treatment supervision plan.

103.10 (b) Treatment supervision must focus on each client's treatment needs and the ability of  
103.11 the staff person under treatment supervision to provide services to each client, including  
103.12 the following topics related to the staff person's current caseload:

103.13 (1) a review and evaluation of the interventions that the staff person delivers to each  
103.14 client;

103.15 (2) instruction on alternative strategies if a client is not achieving treatment goals;

103.16 (3) a review and evaluation of each client's assessments, treatment plans, and progress  
103.17 notes for accuracy and appropriateness;

103.18 (4) instruction on the cultural norms or values of the clients and communities that the  
103.19 license holder serves and the impact that a client's culture has on providing treatment;

103.20 (5) evaluation of and feedback regarding a direct service staff person's areas of  
103.21 competency; ~~and~~

103.22 (6) coaching, teaching, and practicing skills with a staff person; and

103.23 (7) modeling service practices that respect the client, include the client in planning and  
103.24 implementation of the individual treatment plan, recognize the client's strengths, and  
103.25 coordinate with other involved parties and providers.

103.26 (c) A treatment supervisor must provide treatment supervision to a staff person using  
103.27 methods that allow for immediate feedback, including in-person, telephone, and interactive  
103.28 video supervision.

103.29 (d) A treatment supervisor's responsibility for a staff person receiving treatment  
103.30 supervision is limited to the services provided by the associated license holder. If a staff  
103.31 person receiving treatment supervision is employed by multiple license holders, each license

104.1 holder is responsible for providing treatment supervision related to the treatment of the  
104.2 license holder's clients.

104.3 Sec. 25. Minnesota Statutes 2024, section 245I.06, subdivision 2, is amended to read:

104.4 Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff  
104.5 person supervised by the treatment supervisor must develop a written treatment supervision  
104.6 plan. The license holder must ensure that a new staff person's treatment supervision plan is  
104.7 completed, approved by the staff person, and implemented by a treatment supervisor and  
104.8 the new staff person within 30 days of the new staff person's first day of employment. The  
104.9 license holder must review and update each staff person's treatment supervision plan annually.

104.10 (b) Each staff person's treatment supervision plan must include:

104.11 (1) the name and qualifications of the staff person receiving treatment supervision;

104.12 (2) the names and licensures of the treatment supervisors who are supervising the staff  
104.13 person;

104.14 (3) how frequently the treatment supervisors must provide treatment supervision to the  
104.15 staff person; and

104.16 (4) the staff person's authorized scope of practice, including a description of the client  
104.17 ~~population~~ ages that the staff person serves, and a description of the treatment methods and  
104.18 modalities that the staff person may use to provide services to clients.

104.19 Sec. 26. Minnesota Statutes 2024, section 245I.07, is amended to read:

104.20 **245I.07 PERSONNEL FILES.**

104.21 (a) For each staff person, a license holder must maintain a personnel file that includes:

104.22 (1) verification of the staff person's qualifications required for the position including  
104.23 training, education, practicum or internship agreement, licensure, and any other required  
104.24 qualifications;

104.25 (2) documentation related to the staff person's background study;

104.26 (3) the hiring date of the staff person;

104.27 (4) a description of the staff person's job responsibilities with the license holder;

104.28 (5) the date that the staff person's specific duties and responsibilities became effective,  
104.29 including the date that the staff person began having direct contact with clients;

105.1 (6) documentation of the staff person's training as required by section 245I.05, subdivision  
105.2 2;

105.3 (7) a verification copy of license renewals that the staff person completed during the  
105.4 staff person's employment;

105.5 (8) annual job performance evaluations; and

105.6 (9) if applicable, the staff person's alleged and substantiated violations of the license  
105.7 holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license  
105.8 holder's response.

105.9 (b) The license holder must ensure that all personnel files are readily accessible for the  
105.10 commissioner's review. The license holder is not required to keep personnel files in a single  
105.11 location.

105.12 (c) For a license holder under section 245I.17, a personnel file for staff who provide  
105.13 substance use disorder treatment services must include records of training required under  
105.14 section 245G.13, subdivision 2.

105.15 Sec. 27. Minnesota Statutes 2024, section 245I.10, is amended by adding a subdivision  
105.16 to read:

105.17 Subd. 2a. **Evaluation, treatment authorization, and planning in a certified community**  
105.18 **behavioral health clinic.** Notwithstanding subdivisions 2 and 7, a license holder under  
105.19 section 245I.17 must meet the requirements for assessments under section 245I.17,  
105.20 subdivisions 11 and 12, and for treatment planning under section 245I.17, subdivision 13.  
105.21 Certified community behavioral health clinic service planning and authorization must comply  
105.22 with the standards in section 245I.17.

105.23 Sec. 28. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

105.24 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health  
105.25 professional or a clinical trainee may complete a standard diagnostic assessment of a client.  
105.26 A standard diagnostic assessment of a client must include a face-to-face interview with a  
105.27 client and a written evaluation of the client. The assessor must complete a client's standard  
105.28 diagnostic assessment within the client's cultural context. An alcohol and drug counselor  
105.29 may gather and document the information in paragraphs (b) and (c) when completing a  
105.30 comprehensive assessment according to section 245G.05.

106.1 (b) When completing a standard diagnostic assessment of a client, the assessor must  
106.2 gather and document information about the client's current life situation, including the  
106.3 following information:

106.4 (1) the client's age;

106.5 (2) the client's current living situation, including the client's housing status and household  
106.6 members;

106.7 (3) the status of the client's basic needs;

106.8 (4) the client's education level and employment status;

106.9 (5) the client's current medications;

106.10 (6) any immediate risks to the client's health and safety, including withdrawal symptoms,  
106.11 medical conditions, and behavioral and emotional symptoms;

106.12 (7) the client's perceptions of the client's condition;

106.13 (8) the client's description of the client's symptoms, including the reason for the client's  
106.14 referral;

106.15 (9) the client's history of mental health and substance use disorder treatment;

106.16 (10) cultural influences on the client; and

106.17 (11) substance use history, if applicable, including:

106.18 (i) amounts and types of substances, frequency and duration, route of administration,  
106.19 periods of abstinence, and circumstances of relapse; and

106.20 (ii) the impact to functioning when under the influence of substances, including legal  
106.21 interventions.

106.22 (c) If the assessor cannot obtain the information that this paragraph requires without  
106.23 retraumatizing the client or harming the client's willingness to engage in treatment, the  
106.24 assessor must identify which topics will require further assessment during the course of the  
106.25 client's treatment. The assessor must gather and document information related to the following  
106.26 topics:

106.27 (1) the client's relationship with the client's family and other significant personal  
106.28 relationships, including the client's evaluation of the quality of each relationship;

106.29 (2) the client's strengths and resources, including the extent and quality of the client's  
106.30 social networks;

- 107.1 (3) important developmental incidents in the client's life;
- 107.2 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;
- 107.3 (5) the client's history of or exposure to alcohol and drug usage and treatment; and
- 107.4 (6) the client's health history and the client's family health history, including the client's
- 107.5 physical, chemical, and mental health history.

107.6 (d) When completing a standard diagnostic assessment of a client, an assessor must use

107.7 a recognized diagnostic framework.

107.8 (1) When completing a standard diagnostic assessment of a client who is five years of

107.9 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic

107.10 Classification of Mental Health and Development Disorders of Infancy and Early Childhood

107.11 published by Zero to Three.

107.12 (2) When completing a standard diagnostic assessment of a client who is six years of

107.13 age or older, the assessor must use the current edition of the Diagnostic and Statistical

107.14 Manual of Mental Disorders published by the American Psychiatric Association.

107.15 (3) When completing a standard diagnostic assessment of a client who is 12 to 17 years

107.16 of age, an assessor must use either the CRAFFT Questionnaire or the criteria in the most

107.17 recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by

107.18 the American Psychiatric Association to screen and assess the client for a substance use

107.19 disorder.

107.20 ~~(3)~~ (4) When completing a standard diagnostic assessment of a client who is 18 years

107.21 of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the

107.22 criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental

107.23 Disorders published by the American Psychiatric Association to screen and assess the client

107.24 for a substance use disorder.

107.25 (e) When completing a standard diagnostic assessment of a client, the assessor must

107.26 include and document the following components of the assessment:

107.27 (1) the client's mental status examination;

107.28 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;

107.29 vulnerabilities; safety needs, including client information that supports the assessor's findings

107.30 after applying a recognized diagnostic framework from paragraph (d); and any differential

107.31 diagnosis of the client; and

108.1 (3) an explanation of: (i) how the assessor diagnosed the client using the information  
108.2 from the client's interview, assessment, psychological testing, and collateral information  
108.3 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;  
108.4 and (v) the client's responsivity factors.

108.5 (f) When completing a standard diagnostic assessment of a client, the assessor must  
108.6 consult the client and the client's family about which services that the client and the family  
108.7 prefer to treat the client. ~~The assessor must make referrals for the client as to services required~~  
108.8 ~~by law.~~

108.9 (g) Information from other providers and prior assessments may be used to complete  
108.10 the diagnostic assessment if the source of the information is documented in the diagnostic  
108.11 assessment.

108.12 (h) If the client screens positive for a need for substance use disorder treatment services,  
108.13 the assessor must document what actions will be taken to address the client's co-occurring  
108.14 conditions.

108.15 (i) The assessor must determine if the client is eligible for targeted case management  
108.16 services according to section 245.462, subdivision 20, or 245.4871, subdivision 6, and refer  
108.17 the client to the county or contracted provider as appropriate.

108.18 Sec. 29. Minnesota Statutes 2024, section 245I.10, subdivision 8, is amended to read:

108.19 Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's  
108.20 diagnostic assessment or reviewing a client's diagnostic assessment received from a different  
108.21 provider and before providing services to the client beyond those permitted under subdivision  
108.22 7, the license holder must complete the client's individual treatment plan. The license holder  
108.23 must:

108.24 (1) base the client's individual treatment plan on the client's diagnostic assessment and  
108.25 baseline measurements;

108.26 (2) for a child client, use a child-centered, family-driven, and culturally appropriate  
108.27 planning process that allows the child's parents and guardians to observe and participate in  
108.28 the child's individual and family treatment services, assessments, and treatment planning;

108.29 (3) for an adult client, use a person-centered, culturally appropriate planning process  
108.30 that allows the client's family and other natural supports to observe and participate in the  
108.31 client's treatment services, assessments, and treatment planning;

109.1 (4) identify the client's treatment goals, measureable treatment objectives, a schedule  
109.2 for accomplishing the client's treatment goals and objectives, a treatment strategy, and the  
109.3 individuals responsible for providing treatment services and supports to the client. The  
109.4 license holder must have a treatment strategy to engage the client in treatment if the client:

109.5 (i) has a history of not engaging in treatment; and

109.6 (ii) is ordered by a court to participate in treatment services or to take neuroleptic  
109.7 medications;

109.8 (5) identify the participants involved in the client's treatment planning. The client must  
109.9 be a participant in the client's treatment planning. If applicable, the license holder must  
109.10 document the reasons that the license holder did not involve the client's family, case manager,  
109.11 or other natural supports in the client's treatment planning; and

109.12 ~~(6) review the client's individual treatment plan every 180 days and update the client's~~  
109.13 ~~individual treatment plan with the client's treatment progress, new treatment objectives and~~  
109.14 ~~goals or, if the client has not made treatment progress, changes in the license holder's~~  
109.15 ~~approach to treatment; and~~

109.16 ~~(7)~~ (6) ensure that the client approves of the client's individual treatment plan unless a  
109.17 court orders the client's treatment plan under chapter 253B.

109.18 (b) If the client disagrees with the client's treatment plan, the license holder must  
109.19 document in the client file the reasons why the client does not agree with the treatment plan.  
109.20 If the license holder cannot obtain the client's approval of the treatment plan, a mental health  
109.21 professional must make efforts to obtain approval from a person who is authorized to consent  
109.22 on the client's behalf within 30 days after the client's previous individual treatment plan  
109.23 expired. A license holder may not deny a client service during this time period solely because  
109.24 the license holder could not obtain the client's approval of the client's individual treatment  
109.25 plan. A license holder may continue to bill for the client's otherwise eligible services when  
109.26 the client re-engages in services.

109.27 (c) The individual treatment plan must be updated as necessary to reflect the changing  
109.28 needs of the client. The individual treatment plan must provide assistance with accessing  
109.29 necessary crisis services when the license holder is aware of the client's need for crisis  
109.30 services. The license holder must review the client's individual treatment plan every 180  
109.31 days and update the client's individual treatment plan with the client's treatment progress,  
109.32 new treatment objectives and goals, or, if the client has not made treatment progress, changes  
109.33 in the license holder's approach to treatment.

110.1 Sec. 30. [245L.17] CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC  
110.2 LICENSURE.

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

110.5 (b) "Care coordination" means the activities required to coordinate care across settings  
110.6 and providers for an individual served to ensure seamless transitions across the full spectrum  
110.7 of health services. Care coordination includes:

110.8 (1) outreach and engagement;

110.9 (2) documenting a plan of care for medical, behavioral health, and social services and  
110.10 supports in the integrated treatment plan;

110.11 (3) assisting with obtaining appointments;

110.12 (4) confirming appointments are kept;

110.13 (5) developing a crisis plan;

110.14 (6) tracking medication; and

110.15 (7) implementing care coordination agreements with external providers. Care coordination  
110.16 may include psychiatric consultation with primary care practitioners and with mental health  
110.17 clinical care practitioners.

110.18 (c) "Certified community behavioral health clinic" or "CCBHC" means a provider of  
110.19 integrated behavioral health services that is licensed under this section and compliant with  
110.20 federal CCBHC requirements.

110.21 (d) "CCBHC client" means an individual who has participated in a preliminary screening  
110.22 and risk assessment and who has received at least one of the nine required services from a  
110.23 CCBHC.

110.24 (e) "Community needs assessment" means an assessment to identify community needs  
110.25 and determine the community behavioral health clinic's capacity to address the needs of the  
110.26 population being served.

110.27 (f) "Designated collaborating organization" means an entity meeting the requirements  
110.28 of subdivision 5 that has a formal agreement with a CCBHC to furnish CCBHC services.

110.29 (g) "Federal CCBHC criteria" means the most recently issued Certified Community  
110.30 Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental  
110.31 Health Services Administration.

111.1 (h) "Needs assessment" means the community needs assessment described in federal  
111.2 criteria for CCBHC.

111.3 (i) "Preliminary screening and risk assessment" means a mandatory screening and risk  
111.4 assessment that is completed at the time of first contact, whether that contact is in person,  
111.5 by telephone, or using other remote communication.

111.6 Subd. 2. **Establishment of licensure.** (a) The certified community behavioral health  
111.7 clinic model is an integrated service delivery model that uses evidence-based behavioral  
111.8 health practices to achieve better outcomes for individuals experiencing behavioral health  
111.9 concerns while achieving sustainable rates through cost-based reimbursement for providers  
111.10 and economic efficiencies for payors.

111.11 (b) Beginning January 1, 2028, a CCBHC must be licensed under this section and chapter  
111.12 245A.

111.13 (c) A CCBHC must meet the requirements of this section and federal CCBHC criteria.  
111.14 The commissioner may require a CCBHC applicant or license holder to submit documentation  
111.15 of compliance with state licensing requirements and federal CCBHC criteria. When permitted  
111.16 by the Substance Abuse and Mental Health Services Administration, the commissioner may  
111.17 select a transition date on which revisions to the federal CCBHC criteria become required  
111.18 as licensing conditions for CCBHCs.

111.19 Subd. 3. **License extension.** (a) The commissioner must extend a compliant license  
111.20 holder's license under this section for 36 months.

111.21 (b) The commissioner must complete a licensing review that includes an on-site inspection  
111.22 within six months before the expiration of the CCBHC's current license.

111.23 (c) Within 180 days of license expiration, a CCBHC license holder must submit to the  
111.24 commissioner all documentation required by the commissioner under subdivision 2,  
111.25 paragraph (c).

111.26 Subd. 4. **Required services and scope of licensure.** Within a declared service area, the  
111.27 CCBHC must be able to offer:

111.28 (1) mobile crisis services, directly or through a designated collaborating organization  
111.29 under subdivision 4;

111.30 (2) outpatient mental health and substance use disorder treatment services under  
111.31 subdivisions 9 and 10;

111.32 (3) screening, diagnosis, and risk assessment under subdivision 11;

112.1 (4) person- and family-centered treatment planning;

112.2 (5) psychiatric rehabilitation services under subdivision 14;

112.3 (6) community-based mental health care for veterans under subdivision 15;

112.4 (7) outpatient primary care screening and monitoring under subdivision 16;

112.5 (8) peer services under subdivision 17; and

112.6 (9) targeted case management under subdivision 18.

112.7 Subd. 5. **Designated collaborating organization.** (a) If a CCBHC is unable to provide  
112.8 mobile crisis services, the CCBHC may contract with another entity that is licensed to  
112.9 provide mobile crisis services under section 245I.24 and that meets the requirements of the  
112.10 federal CCBHC criteria as a designated collaborating organization.

112.11 (b) The CCBHC must submit a designated collaborating organization arrangement for  
112.12 approval to the commissioner as part of the licensing process.

112.13 Subd. 6. **Exemptions to host county approval.** Notwithstanding any other law that  
112.14 requires a county contract or other form of county approval for a service listed in subdivision  
112.15 4, a CCBHC that meets the requirements of this section may receive the prospective payment  
112.16 under section 256B.0625, subdivision 5m, for that service without a county contract or  
112.17 county approval.

112.18 Subd. 7. **Variances.** When the standards listed in this section or other applicable standards  
112.19 conflict or address similar issues in duplicative or incompatible ways, the commissioner  
112.20 may grant variances to state requirements if the variances do not conflict with federal  
112.21 requirements for services reimbursed under medical assistance. If standards overlap, the  
112.22 commissioner may substitute all or a part of a licensure or certification that is substantially  
112.23 the same as another licensure or certification. The commissioner must consult with  
112.24 stakeholders before granting variances under this provision. For a CCBHC that is licensed  
112.25 but not approved for prospective payment under section 256B.0625, subdivision 5m, the  
112.26 commissioner may grant a variance under this paragraph if the variance does not increase  
112.27 the state share of costs.

112.28 Subd. 8. **Evidence-based practices.** The commissioner must issue a list of required  
112.29 evidence-based practices to be delivered by CCBHCs and may also provide a list of  
112.30 recommended evidence-based practices. The commissioner may update the list to reflect  
112.31 advances in outcomes research and medical services for persons living with mental illnesses  
112.32 or substance use disorders. When developing the list, the commissioner must consider the  
112.33 adequacy of evidence to support the efficacy of the practice across cultures and ages, the

113.1 workforce available, and the current availability of the practices in the state. At least 30  
113.2 days before issuing the initial list or issuing any revisions, the commissioner must provide  
113.3 stakeholders with an opportunity to comment.

113.4 Subd. 9. **Outpatient mental health services.** (a) A license holder must provide outpatient  
113.5 mental health services that comply with the federal CCBHC criteria and applicable state  
113.6 standards in this chapter, except as provided in this subdivision.

113.7 (b) Completion of an initial or comprehensive evaluation fulfills the requirements to  
113.8 perform a diagnostic assessment in accordance with section 245I.10, subdivisions 2 and 6.

113.9 (c) An integrated treatment plan under this section fulfills the requirements to conduct  
113.10 treatment planning in accordance with section 245I.10, subdivisions 7 and 8.

113.11 (d) A license holder under this section is exempt from certification as a mental health  
113.12 clinic under section 245I.20.

113.13 Subd. 10. **Outpatient substance use disorder treatment.** (a) When a license holder  
113.14 provides substance use disorder treatment services to an individual with a substance use  
113.15 disorder diagnosis, the license holder must comply with the requirements for substance use  
113.16 disorder treatment services in chapter 245G, except as provided in this subdivision.

113.17 (b) Completion of a preliminary screening and risk assessment under this section fulfills  
113.18 the requirements to complete an initial services plan under section 245G.04, subdivision 1.

113.19 (c) Completion of a comprehensive evaluation under this section fulfills the requirements  
113.20 to administer a comprehensive assessment under section 245G.05.

113.21 (d) An integrated treatment plan under this section that contains a six-dimension analysis  
113.22 of the client's needs according to the third edition of ASAM criteria, as defined in section  
113.23 254B.01, subdivision 2a, fulfills the requirements to provide an individual treatment plan  
113.24 under section 245G.06.

113.25 (e) A license holder under this section fulfills the requirement to document personnel  
113.26 files under section 245G.13, subdivision 3, by complying with the requirements of this  
113.27 chapter.

113.28 (f) A license holder under this section fulfills the requirement to protect client rights  
113.29 under section 245G.15 by complying with the requirements of section 245I.12.

113.30 (g) A license holder under this section fulfills the requirements to respond to behavioral  
113.31 emergencies under section 245G.16 by complying with the requirements of section 245I.03,  
113.32 subdivision 4.

114.1 (h) A license holder under this section is exempt from licensure under chapter 245G.

114.2 Subd. 11. **Initial triage and risk assessment.** (a) A license holder must have policies  
114.3 and procedures on:

114.4 (1) how staff will implement the requirements of this subdivision;

114.5 (2) staff positions authorized to complete triage and risk assessments;

114.6 (3) documenting the results of the risk screenings; and

114.7 (4) ensuring the client is offered timely services according to the federal CCBHC criteria.

114.8 (b) A license holder must conduct an initial triage and risk assessment when a new client  
114.9 requests services or is referred to services. A license holder may conduct an initial triage  
114.10 and risk assessment in person, by telephone, or through other remote communication. Based  
114.11 on the acuity of needs as assessed in the initial triage and risk assessment, the client must  
114.12 be categorized as having emergency, urgent, or routine needs.

114.13 (c) Based on these categorizations, the license holder must offer services that meet the  
114.14 relevant timelines under the federal CCBHC criteria.

114.15 (d) The license holder must provide training that addresses:

114.16 (1) when a prospective client requires intervention from qualified staff;

114.17 (2) the use of standardized measures that screen for significant risks;

114.18 (3) other factors that indicate a client has urgent needs besides the Columbia Suicide  
114.19 Severity Rating Scale or a self-harm screening; and

114.20 (4) overdose and substance use disorder risks.

114.21 Subd. 12. **Initial and comprehensive evaluation.** (a) A license holder under this section  
114.22 must provide initial and comprehensive evaluations according to this section and federal  
114.23 CCBHC criteria.

114.24 (b) An initial evaluation is necessary to authorize the provision of all medically necessary  
114.25 CCBHC services until the completion of a comprehensive evaluation. A comprehensive  
114.26 evaluation is necessary to authorize the provision of all medically necessary CCBHC services  
114.27 on an ongoing basis. A license holder must ensure that each client's comprehensive evaluation  
114.28 reflects the needs and assessments for all services provided.

114.29 Subd. 13. **Integrated treatment plan.** (a) A license holder under this section must  
114.30 complete an integrated treatment plan for each client following the client's comprehensive  
114.31 evaluation no later than 60 calendar days after the date of the first request for services.

115.1 (b) A license holder must document all required services under subdivision 9 within the  
115.2 integrated treatment plan based on the client's needs.

115.3 (c) A license holder must review and update a client's integrated treatment plan as  
115.4 necessary to reflect the changing needs of the client and progress made in treatment. If the  
115.5 client has not made treatment progress, updates to the treatment plan must indicate changes  
115.6 in the license holder's approach to treatment to better meet the needs of the client. A license  
115.7 holder must review and update the integrated treatment plan at least every 180 days or as  
115.8 clinically indicated.

115.9 Subd. 14. **Psychiatric rehabilitation services.** (a) For children, a license holder under  
115.10 this section must provide children's therapeutic services and supports according to sections  
115.11 245I.30 and 245I.31, except that an initial or comprehensive assessment under this section  
115.12 fulfills the requirement to perform a standard diagnostic assessment.

115.13 (b) For adults, a license holder under this section must provide adult rehabilitative mental  
115.14 health services according to section 245I.22, except that:

115.15 (1) the license holder is exempt from the requirement to perform a level of care  
115.16 assessment under section 245I.22, subdivision 6, paragraph (b); and

115.17 (2) an initial or comprehensive assessment under this section fulfills the requirement to  
115.18 perform a standard diagnostic assessment.

115.19 Subd. 15. **Community-based care for veterans.** (a) The license holder must provide  
115.20 services according to federal requirements for eligibility and coordination with TRICARE  
115.21 and the United States Department of Veterans Affairs.

115.22 (b) The license holder must assign and document a principal behavioral health provider  
115.23 for every veteran receiving services.

115.24 Subd. 16. **Primary care screening and monitoring.** To fulfill the requirements for  
115.25 primary care screening, a license holder under this section must have policies and procedures  
115.26 detailing the screenings to be performed with specific populations at the clinic. The policies  
115.27 and procedures must be approved by the medical director.

115.28 Subd. 17. **Peer services.** A license holder must be able to provide peer services as  
115.29 described by federal CCBHC criteria and sections 245G.07, subdivision 2, clause (8),  
115.30 256B.0615, and 256B.0616.

115.31 Subd. 18. **Targeted case management.** (a) A license holder must provide mental health  
115.32 targeted case management as described by federal CCBHC criteria and section 256B.0625,  
115.33 subdivision 20.

116.1 (b) An initial or comprehensive evaluation under this section fulfills any requirement  
116.2 to perform a standard diagnostic assessment for targeted case management.

116.3 Subd. 19. **Community needs assessment.** (a) The community needs assessment must  
116.4 be a collaborative document that reflects the license holder's or applicant's engagement with  
116.5 current clients, other social and medical services agencies, community groups, underserved  
116.6 populations, and government agencies. The applicant or license holder must document an  
116.7 outreach plan within the community needs assessment to demonstrate how stakeholder  
116.8 feedback was solicited and reflected in the plan.

116.9 (b) The applicant or license holder must publicly post a draft community needs assessment  
116.10 on the organization's website for 30 days and submit a summary of public comments and  
116.11 recommendations from the comment period to the commissioner.

116.12 (c) In the draft community needs assessment, the applicant or license holder must declare  
116.13 a planned geographic service delivery area in which the CCBHC will be capable of providing  
116.14 all nine required services. An applicant must provide an analysis of how CCBHC status  
116.15 will lead to a significant improvement in the availability and quality of the services. An  
116.16 existing license holder must include analysis of which needs from prior needs assessments  
116.17 have been improved by the operation of the CCBHC. A clinic that has not made and  
116.18 demonstrated substantial progress in addressing the identified needs must specify what  
116.19 changes will occur to address the lack of progress.

116.20 (d) The commissioner must provide feedback and technical assistance if the community  
116.21 needs assessment must be revised.

116.22 Subd. 20. **Staffing plan.** Based on an accepted community needs assessment, the  
116.23 applicant or license holder must complete a staffing plan. The staffing plan must include  
116.24 analysis of the extent to which identified staffing levels will be capable of meeting the needs  
116.25 identified in the community needs assessment.

116.26 Subd. 21. **Data and evaluation.** A provider must submit documentation that establishes  
116.27 the ability of the clinic to complete the required data collection as a CCBHC, as determined  
116.28 by the commissioner. For an applicant that is an existing provider, the commissioner must  
116.29 review and evaluate data submitted related to claims, grants, and other reporting to ensure  
116.30 the data meets reporting requirements.

116.31 Subd. 22. **Cost reporting.** A provider must submit a cost report on the forms and in the  
116.32 manner required in section 256B.0625, subdivision 5m.

117.1 Sec. 31. [245I.22] ADULT REHABILITATIVE MENTAL HEALTH SERVICES.

117.2 Subdivision 1. Generally. Beginning January 1, 2028, a provider of adult mental health  
117.3 rehabilitative services must be licensed under this section and chapter 245A.

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

117.6 (b) "Adult mental health rehabilitative services" or "ARMHS" has the meaning given  
117.7 in section 245I.02, subdivision 33.

117.8 (c) "Basic living skills" means rehabilitative interventions that instruct, assist, and support  
117.9 the client with:

117.10 (1) interpersonal communication skills;

117.11 (2) community resource utilization and integration skills;

117.12 (3) crisis planning;

117.13 (4) relapse prevention skills;

117.14 (5) health care directives;

117.15 (6) budgeting and shopping skills;

117.16 (7) healthy lifestyle skills and practices;

117.17 (8) cooking and nutrition skills;

117.18 (9) transportation skills;

117.19 (10) mental illness symptom management skills;

117.20 (11) household management skills;

117.21 (12) employment-related skills; and

117.22 (13) parenting skills.

117.23 (d) "Community intervention" means a client's community assisting in the client's  
117.24 rehabilitation, including consultation with relatives, guardians, friends, employers, treatment  
117.25 providers, and other significant individuals. Community intervention is appropriate when  
117.26 directed exclusively to the treatment of the client.

117.27 (e) "Medication education services" means services provided individually or in groups  
117.28 that focus on educating the client about mental illness and symptoms, the role and effects  
117.29 of medications in treating symptoms of mental illness, and the side effects of medications.  
117.30 Medication education services must be coordinated with, but must not duplicate, medication

118.1 management services. Medication education services must be provided by physicians,  
118.2 advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

118.3 (f) "Transition to community living services" means services that maintain continuity  
118.4 of contact between the ARMHS provider and the client and facilitate discharge from a  
118.5 hospital, residential treatment program, board and lodging facility, or nursing home.  
118.6 Transition to community living services must not be used to provide other areas of adult  
118.7 rehabilitative mental health services.

118.8 Subd. 3. **Service components.** An ARMHS provider must be capable of providing:

118.9 (1) basic living skills;

118.10 (2) medication education services;

118.11 (3) community intervention; and

118.12 (4) transition to community living services.

118.13 Subd. 4. **Provider requirements.** An ARMHS license holder must be enrolled with  
118.14 medical assistance and comply with standards in section 256B.0623.

118.15 Subd. 5. **Qualifications.** ARMHS must be provided by:

118.16 (1) a mental health professional qualified under section 245I.04, subdivision 2;

118.17 (2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

118.18 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

118.19 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

118.20 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision  
118.21 12; or

118.22 (6) a mental health rehabilitation worker qualified under section 245I.04, subdivision  
118.23 14.

118.24 Subd. 6. **Service planning.** (a) An ARMHS provider must complete a written functional  
118.25 assessment according to section 245I.10, subdivision 9, for each client.

118.26 (b) When an ARMHS provider completes a written functional assessment, the provider  
118.27 must also complete a level of care assessment, as defined in section 245I.02, subdivision  
118.28 19, for the client.

118.29 Subd. 7. **Group modality.** ARMHS may be provided in group settings if appropriate  
118.30 to each participating client's needs and treatment plan. A group is defined as two to ten

119.1 clients, at least one of whom is concurrently receiving ARMHS. The service and group  
119.2 must be specified in the client's individual treatment plan.

119.3 **Sec. 32. [245I.24] MOBILE CRISIS RESPONSE SERVICES.**

119.4 Subdivision 1. **Generally.** (a) Mobile crisis response services provide short-term,  
119.5 face-to-face mental health care in community settings for adults and children experiencing  
119.6 crisis to help individuals maintain safety and return to a baseline level of functioning.

119.7 (b) Beginning January 1, 2028, a provider of mobile crisis response services must be  
119.8 licensed under this section and chapter 245A.

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

119.11 (b) "Crisis assessment" means an immediate face-to-face assessment by a physician, a  
119.12 mental health professional, or a qualified member of a crisis team, as described in subdivision  
119.13 5.

119.14 (c) "Crisis intervention" means face-to-face, short-term intensive mental health services  
119.15 initiated during a mental health crisis to help an individual cope with immediate stressors,  
119.16 identify and utilize available resources and strengths, engage in voluntary treatment, and  
119.17 begin to return to the individual's baseline level of functioning.

119.18 (d) "Crisis screening" means a screening of a client's potential mental health crisis  
119.19 situation under subdivision 6.

119.20 (e) "Crisis stabilization services" means individualized mental health services that are  
119.21 designed to restore an individual to the individual's baseline level of functioning. Crisis  
119.22 stabilization services may be provided in the individual's home, the home of a family member  
119.23 or friend of the individual, another community setting, a short-term supervised licensed  
119.24 residential program, or an emergency department. Crisis stabilization services include family  
119.25 psychoeducation.

119.26 (f) "Crisis team" means the staff of a provider entity who are supervised and prepared  
119.27 to provide mobile crisis services to a client in a potential mental health crisis situation.

119.28 (g) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without  
119.29 the provision of crisis response services, would likely result in significantly reducing the  
119.30 individual's levels of functioning in primary activities of daily living, the individual needing  
119.31 emergency services under section 62Q.55, or the individual being placed in a more restrictive  
119.32 setting, including but not limited to inpatient hospitalization.

120.1 (h) "Mobile crisis services" means screening, assessment, intervention, and  
120.2 community-based crisis stabilization services that are provided to an individual client.  
120.3 Mobile crisis services does not include residential crisis stabilization.

120.4 Subd. 3. **Eligibility.** (a) An individual is eligible for crisis assessment services when the  
120.5 person has screened positive for a potential mental health crisis during a crisis screening.

120.6 (b) An individual is eligible for crisis intervention services and crisis stabilization services  
120.7 when the individual has been assessed during a crisis assessment to be experiencing a mental  
120.8 health crisis.

120.9 Subd. 4. **Policies, procedures, and practices specified.** (a) In addition to the policies  
120.10 and procedures required by section 245I.03, the license holder must establish, enforce, and  
120.11 maintain policies and procedures to:

120.12 (1) ensure that crisis screenings, crisis assessments, and crisis intervention services are  
120.13 available 24 hours per day, seven days per week;

120.14 (2) respond to a call for services in a designated service area or according to a written  
120.15 agreement with the local mental health authority for an adjacent area;

120.16 (3) have at least one mental health professional on staff at all times and at least one  
120.17 additional staff member capable of leading a crisis response in the community; and

120.18 (4) respond to clients in the community according to the requirements and priorities in  
120.19 subdivision 6.

120.20 (b) The license holder must provide the commissioner with information about the number  
120.21 of requests for service, the number of clients that the provider serves face-to-face, and client  
120.22 outcomes at least every six months, in a form and manner prescribed by the commissioner.

120.23 (c) The license holder must:

120.24 (1) provide support for an individual's family and natural supports by enabling the  
120.25 individual's family and natural supports to observe and participate in the individual's  
120.26 treatment, assessments, and planning services;

120.27 (2) implement culturally specific treatment identified in the crisis treatment plan that is  
120.28 meaningful and appropriate, as determined by the individual's culture, beliefs, values, and  
120.29 language;

120.30 (3) respond to an individual's changing intervention and care needs, as identified by the  
120.31 individual or a family member; and

121.1 (4) have the communication tools and procedures to communicate and consult promptly  
121.2 about crisis assessment and interventions as services are provided.

121.3 (d) The license holder must coordinate services with:

121.4 (1) county emergency services under section 245.469, community hospitals, ambulance  
121.5 services, transportation services, social services, law enforcement, engagement services,  
121.6 and mental health crisis services through regularly scheduled interagency meetings;

121.7 (2) other behavioral health service providers, county mental health authorities, or federally  
121.8 recognized American Indian authorities, and others as necessary, with the consent of the  
121.9 individual or parent or guardian;

121.10 (3) detoxification, withdrawal management services, and medical stabilization services  
121.11 as needed; and

121.12 (4) the individual's case manager if the individual is receiving case management services.

121.13 Subd. 5. Crisis assessment and intervention staff qualifications. (a) Crisis assessment  
121.14 and intervention services must be provided by:

121.15 (1) a mental health professional qualified under section 245I.04, subdivision 2;

121.16 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

121.17 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

121.18 (4) a mental health certified family peer specialist qualified under section 245I.04,  
121.19 subdivision 12; or

121.20 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision  
121.21 10.

121.22 (b) When crisis assessment and intervention services are provided to an individual in  
121.23 the community, a mental health professional, clinical trainee, or mental health practitioner  
121.24 must lead the response.

121.25 (c) For providers under this section, the 30 hours of ongoing training required by section  
121.26 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children  
121.27 and adults and include training about evidence-based practices identified by the commissioner  
121.28 of health to reduce the individual's risk of suicide and self-injurious behavior.

121.29 (d) At least six hours of the ongoing training under paragraph (c) must be specific to  
121.30 working with families and providing crisis stabilization services to children and include the  
121.31 following topics:

- 122.1 (1) developmental tasks of childhood and adolescence;
- 122.2 (2) family relationships;
- 122.3 (3) child and youth engagement and motivation, including motivational interviewing;
- 122.4 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
- 122.5 queer youth;
- 122.6 (5) positive behavior support;
- 122.7 (6) crisis intervention for youth with developmental disabilities;
- 122.8 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
- 122.9 therapy; and
- 122.10 (8) youth substance use.
- 122.11 (e) Individual providers must be experienced in crisis assessment, crisis intervention
- 122.12 techniques, treatment engagement strategies, working with families, and clinical decision
- 122.13 making under emergency conditions and have knowledge of local services and resources.
- 122.14 Subd. 6. Crisis screening. (a) A license holder may use the resources of emergency
- 122.15 services under section 245.469 for crisis screening. The crisis screening must gather
- 122.16 information, determine whether a mental health crisis situation exists, identify parties
- 122.17 involved, and determine an appropriate response.
- 122.18 (b) When conducting a crisis screening, a provider must:
- 122.19 (1) employ evidence-based practices to reduce the individual's risk of suicide and
- 122.20 self-injurious behavior;
- 122.21 (2) work with the individual to establish a plan and time frame for responding to the
- 122.22 individual's mental health crisis, including responding to the individual's immediate need
- 122.23 for support by telephone or text message until the provider can respond to the individual
- 122.24 face-to-face;
- 122.25 (3) document significant factors in determining whether the individual is experiencing
- 122.26 a mental health crisis, including prior requests for crisis services, an individual's recent
- 122.27 presentation at an emergency department, known calls to 911 or law enforcement, or
- 122.28 information from third parties with knowledge of an individual's history or current needs;
- 122.29 (4) accept calls from interested third parties and consider the additional needs or potential
- 122.30 mental health crises that the third parties may be experiencing;

123.1 (5) provide psychoeducation, including reducing access to means of suicide, to relevant  
123.2 third parties including family members or other persons living with the individual; and

123.3 (6) consider other available services to determine which service intervention would best  
123.4 address the individual's needs and circumstances.

123.5 (c) For purposes of this section, the following situations indicate a positive screen for a  
123.6 potential mental health crisis:

123.7 (1) the individual presents at an emergency department or urgent care setting and the  
123.8 health care team at that location requested crisis services; or

123.9 (2) a peace officer requested crisis services for an individual who is potentially subject  
123.10 to transportation under section 253B.051.

123.11 (d) The provider must prioritize providing a face-to-face crisis assessment of the  
123.12 individual, unless a provider documents specific evidence to show why the face-to-face  
123.13 assessment was not possible, including insufficient staffing resources, concerns for staff or  
123.14 individual safety, or other clinical factors.

123.15 (e) A provider is not required to have direct contact with the individual to determine  
123.16 that the individual is experiencing a potential mental health crisis. A mobile crisis provider  
123.17 may gather relevant information about the individual from a third party to establish the  
123.18 individual's need for services and potential safety factors.

123.19 Subd. 7. **Crisis assessment.** (a) If an individual screens positive for a potential mental  
123.20 health crisis, a crisis assessment must be completed. A crisis assessment must evaluate any  
123.21 immediate needs for which services are needed and, as time permits, the individual's:

123.22 (1) current life situation;

123.23 (2) health information, including current medications;

123.24 (3) sources of stress;

123.25 (4) mental health problems and symptoms;

123.26 (5) strengths;

123.27 (6) cultural considerations;

123.28 (7) support network;

123.29 (8) vulnerabilities;

123.30 (9) current functioning; and

124.1 (10) preferences, as communicated directly by the individual or as communicated in a  
124.2 health care directive as described in chapters 145C and 253B, the crisis treatment plan  
124.3 described in subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

124.4 (b) A provider must conduct a crisis assessment at the individual's location when  
124.5 appropriate and, when not appropriate, document the reasons.

124.6 (c) Whenever possible, the assessor must attempt to include input from the individual,  
124.7 the individual's family, and other natural supports to assess whether a crisis exists.

124.8 (d) A crisis assessment must include a determination of:

124.9 (1) whether the individual is willing to voluntarily engage in treatment;

124.10 (2) whether the individual has an advance directive; and

124.11 (3) gathering the individual's information and history from involved family or other  
124.12 natural supports.

124.13 (e) If a team determines that the individual does not need an acute level of care, the team  
124.14 must provide services or service coordination if the individual has a co-occurring substance  
124.15 use disorder and is otherwise eligible for services.

124.16 (f) If, after completing a crisis assessment, a provider refers the individual to an intensive  
124.17 setting, including an emergency department, inpatient hospitalization, or residential crisis  
124.18 stabilization, one of the crisis team members who completed or conferred about the  
124.19 individual's crisis assessment must immediately contact the referral entity and consult with  
124.20 the staff responsible for triage or intake at the referral entity. During the consultation, the  
124.21 crisis team member must convey key findings or concerns that led to the individual's referral.  
124.22 Following the consultation, the provider must also send written documentation to the referral  
124.23 entity. The provider must document if the individual or the individual's legal guardian signed  
124.24 releases for health records or if an exception under section 144.293, subdivision 5, exists.

124.25 Subd. 8. **Crisis intervention services.** (a) If the crisis assessment determines an individual  
124.26 needs mobile crisis intervention services, the license holder must provide crisis intervention  
124.27 services promptly. As able during the intervention, at least two members of the mobile crisis  
124.28 intervention team must confer directly or by telephone about the crisis assessment, crisis  
124.29 treatment plan, and actions taken and needed. At least one of the team members must be  
124.30 providing face-to-face crisis intervention services. If providing crisis intervention services,  
124.31 a clinical trainee or mental health practitioner must seek treatment supervision as required  
124.32 in subdivision 10.

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

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

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

125.7 (e) If the individual's mental health crisis is stabilized, but the individual needs a referral  
125.8 to other services, the team must provide referrals to these services. If the individual is unable  
125.9 to follow up on the referral, the team must link the individual to the service and follow up  
125.10 to ensure the individual is receiving the service.

125.11 Subd. 9. **Crisis stabilization services.** (a) Crisis stabilization services must be provided  
125.12 by qualified staff of a crisis stabilization services provider entity, which must:

125.13 (1) develop a crisis treatment plan that meets the criteria in subdivision 11;

125.14 (2) complete a vulnerable adult determination in accordance with section 245A.65,  
125.15 subdivision 1a;

125.16 (3) deliver crisis stabilization services according to the crisis treatment plan and include  
125.17 face-to-face contact with the individual receiving services by qualified staff for further  
125.18 assessment, help with referrals, updating of the crisis treatment plan, skills training, and  
125.19 collaboration with other service providers in the community;

125.20 (4) if the provider delivers crisis stabilization services while the individual is absent,  
125.21 document the reason for delivering services while the individual is absent; and

125.22 (5) if the individual's mental health crisis is stabilized and the individual does not have  
125.23 a health care directive or psychiatric declaration, as defined in chapter 145C or section  
125.24 253B.03, subdivision 6d, offer to work with the individual to develop a directive or  
125.25 declaration.

125.26 (b) A staff member providing crisis stabilization services must be:

125.27 (1) a mental health professional qualified under section 245I.04, subdivision 2;

125.28 (2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

125.29 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

125.30 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

126.1 (5) a mental health certified family peer specialist qualified under section 245I.04,  
126.2 subdivision 12;

126.3 (6) a mental health certified peer specialist qualified under section 245I.04, subdivision  
126.4 10; or

126.5 (7) a mental health rehabilitation worker qualified under section 245I.04, subdivision  
126.6 14.

126.7 (c) For providers under this section, the 30 hours of ongoing training required in section  
126.8 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children  
126.9 and adults and include training about evidence-based practices identified by the commissioner  
126.10 of health to reduce an individual's risk of suicide and self-injurious behavior.

126.11 (d) For providers who deliver care to children 21 years of age or younger, at least six  
126.12 hours of the ongoing training under this subdivision must be specific to working with families  
126.13 and providing crisis stabilization services to children, including the following topics:

126.14 (1) developmental tasks of childhood and adolescence;

126.15 (2) family relationships;

126.16 (3) child and youth engagement and motivation, including motivational interviewing;

126.17 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and  
126.18 queer youth;

126.19 (5) positive behavior support;

126.20 (6) crisis intervention for youth with developmental disabilities;

126.21 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral  
126.22 therapy; and

126.23 (8) youth substance use.

126.24 This paragraph does not apply to adult residential crisis stabilization services providers  
126.25 licensed under section 245I.23 or providing services pursuant to section 256B.0624,  
126.26 subdivision 7a.

126.27 Subd. 10. **Supervision.** Clinical trainees and mental health practitioners may provide  
126.28 crisis assessment and crisis intervention services if the following treatment supervision  
126.29 requirements are met:

126.30 (1) the license holder must accept full responsibility for the services provided;

- 127.1 (2) a mental health professional working for the license holder must be immediately  
127.2 available by telephone or in person for treatment supervision;
- 127.3 (3) a mental health professional must be consulted, in person or by telephone, during  
127.4 the first three hours when a clinical trainee or mental health practitioner provides crisis  
127.5 assessment or crisis intervention services; and
- 127.6 (4) a mental health professional must:
- 127.7 (i) review and approve, as defined in section 245I.02, subdivision 2, the tentative crisis  
127.8 assessment and crisis treatment plan within 24 hours of first providing services to the  
127.9 individual, notwithstanding section 245I.08, subdivision 3; and
- 127.10 (ii) document the consultation required in clause (3).
- 127.11 Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of an individual's admission, the  
127.12 license holder must complete the individual's crisis treatment plan. The license holder must:
- 127.13 (1) base the individual's crisis treatment plan on the individual's crisis assessment;
- 127.14 (2) consider crisis assistance strategies that have been effective for the individual in the  
127.15 past;
- 127.16 (3) for a child, use a child-centered, family-driven, and culturally appropriate planning  
127.17 process that allows the child's parents and guardians to observe or participate in the child's  
127.18 individual and family treatment services, assessment, and treatment planning;
- 127.19 (4) for an adult, use a person-centered, culturally appropriate planning process that allows  
127.20 the individual's family and other natural supports to observe or participate in treatment  
127.21 services, assessment, and treatment planning;
- 127.22 (5) identify the participants involved in the individual's treatment planning. The individual  
127.23 must be a participant if possible;
- 127.24 (6) identify the individual's initial treatment goals, measurable treatment objectives, and  
127.25 specific interventions that the license holder will use to help the person engage in treatment;
- 127.26 (7) include documentation of referral to and scheduling of services, including specific  
127.27 providers where applicable;
- 127.28 (8) ensure that the individual or the individual's legal guardian approves under section  
127.29 245I.02, subdivision 2, of the individual's crisis treatment plan unless a court orders the  
127.30 individual's treatment plan under chapter 253B. If the individual or the individual's legal  
127.31 guardian disagrees with the crisis treatment plan, the license holder must document in the  
127.32 client file the reasons why the individual disagrees with the crisis treatment plan; and

128.1 (9) ensure that a treatment supervisor approves, as defined in section 245I.02, subdivision  
128.2 2, of the individual's treatment plan within 24 hours of the individual's admission if a mental  
128.3 health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding  
128.4 section 245I.08, subdivision 3.

128.5 (b) The provider entity must provide the individual and the individual's legal guardian  
128.6 with a copy of the crisis treatment plan.

128.7 Subd. 12. **Application requirements.** In a licensing application submitted under this  
128.8 section and section 245A.04, the applicant must demonstrate that the applicant is:

128.9 (1) enrolled as a medical assistance provider; and

128.10 (2) in compliance with the provider type requirements under section 256B.0624,  
128.11 subdivision 4, as determined by the commissioner.

128.12 Sec. 33. **[245I.30] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

128.13 Subdivision 1. **Generally.** (a) "Children's therapeutic services and supports" means a  
128.14 flexible package of community-based mental health services for children who require varying  
128.15 therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness.  
128.16 Interventions are delivered using various treatment modalities and combinations of services  
128.17 designed to reach treatment outcomes identified in the individual treatment plan. Children's  
128.18 therapeutic services and supports include development and rehabilitative services that  
128.19 support a child's developmental treatment needs.

128.20 (b) Beginning January 1, 2028, a provider of children's therapeutic services and supports  
128.21 must be licensed under this section and chapter 245A.

128.22 Subd. 2. **Service components.** (a) A children's therapeutic services and supports license  
128.23 holder must be capable of providing:

128.24 (1) individual and family psychotherapy, psychotherapy for crises, and group  
128.25 psychotherapy;

128.26 (2) individual, family, or group skills training; and

128.27 (3) crisis planning.

128.28 (b) Crisis planning that meets the standards in section 245.4871, subdivision 9a, must  
128.29 be offered to each client's family.

129.1 Subd. 3. **Provider requirements.** A children's therapeutic services and supports license  
129.2 holder must be enrolled with medical assistance and comply with the requirements in section  
129.3 256B.0943.

129.4 Subd. 4. **Qualifications of provider staff.** Children's therapeutic services and supports  
129.5 must be provided by:

129.6 (1) a mental health professional qualified under section 245I.04, subdivision 2;

129.7 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

129.8 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

129.9 (4) a mental health certified family peer specialist qualified under section 245I.04,  
129.10 subdivision 12; or

129.11 (5) a mental health behavioral aide qualified under section 245I.04, subdivision 16.

129.12 Subd. 5. **Group modality.** Group skills training may be provided to multiple clients  
129.13 who, because of the nature of the clients' emotional, behavioral, or social dysfunction, can  
129.14 derive mutual benefit from interaction in a group setting. A group must consist of two to  
129.15 ten clients, at least one of whom is a client and is concurrently receiving a service under  
129.16 this section. The service and group must be specified in the client's individual treatment  
129.17 plan.

129.18 Sec. 34. **[245I.31] CHILDREN'S DAY TREATMENT.**

129.19 Subdivision 1. **Generally.** (a) For purposes of this section, "children's day treatment  
129.20 program" means a site-based structured mental health program consisting of psychotherapy  
129.21 and individual or group skills training provided by a team under the treatment supervision  
129.22 of a mental health professional.

129.23 (b) A children's day treatment program must be licensed for a specific location of  
129.24 operation and must not be part of inpatient or residential treatment services.

129.25 (c) A children's day treatment program must stabilize a client's mental health status while  
129.26 developing and improving the client's independent living and socialization skills. The goal  
129.27 of the day treatment program must be to reduce or relieve the effects of mental illness and  
129.28 provide training to enable the client to live in the community.

129.29 (d) Beginning January 1, 2028, a provider of children's day services must be licensed  
129.30 under this section and chapter 245A.

130.1 Subd. 2. **Service components.** A children's day treatment program must be capable of  
130.2 providing the services in section 245I.30, subdivision 2.

130.3 Subd. 3. **Provider requirements.** A children's day treatment license holder must:

130.4 (1) be enrolled as a provider with medical assistance;

130.5 (2) maintain a policy regarding the use of restrictive procedures and meet the requirements  
130.6 of section 245.8261;

130.7 (3) maintain a policy on medications in accordance with section 245I.11, subdivision  
130.8 6; and

130.9 (4) meet group modality requirements in section 245I.30, subdivision 5.

130.10 Subd. 4. **Qualifications of provider staff.** Children's day treatment services must be  
130.11 provided by:

130.12 (1) a mental health professional qualified under section 245I.04, subdivision 2;

130.13 (2) a clinical trainee qualified under section 245I.04, subdivision 6; or

130.14 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4.

130.15 Sec. 35. Minnesota Statutes 2024, section 256B.0623, subdivision 1, is amended to read:

130.16 Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically  
130.17 necessary adult rehabilitative mental health services when the services are provided by an  
130.18 entity ~~meeting the standards in this section~~ licensed under section 245I.24. The provider  
130.19 entity must make reasonable and good faith efforts to report individual client outcomes to  
130.20 the commissioner, using instruments and protocols approved by the commissioner.

130.21 **EFFECTIVE DATE.** This section is effective January 1, 2028.

130.22 Sec. 36. Minnesota Statutes 2024, section 256B.0623, subdivision 3, is amended to read:

130.23 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

130.24 (1) is age 18 or older;

130.25 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain  
130.26 injury, for which adult rehabilitative mental health services are needed;

130.27 (3) has substantial disability and functional impairment in three or more of the areas  
130.28 listed in section 245I.10, subdivision 9, paragraph (a), clause (4), so that self-sufficiency is  
130.29 markedly reduced; and

131.1 (4) has had a recent standard diagnostic assessment pursuant to section 245I.10,  
131.2 subdivision 6, by a qualified professional that documents adult rehabilitative mental health  
131.3 services are medically necessary to address identified disability and functional impairments  
131.4 and individual recipient goals.

131.5 **EFFECTIVE DATE.** This section is effective January 1, 2028.

131.6 Sec. 37. Minnesota Statutes 2024, section 256B.0623, subdivision 12, is amended to read:

131.7 Subd. 12. **Additional requirements.** ~~(a) Providers of adult rehabilitative mental health~~  
131.8 ~~services must comply with the requirements relating to referrals for case management in~~  
131.9 ~~section 245.467, subdivision 4.~~

131.10 ~~(b) Adult rehabilitative mental health services are provided for most recipients in the~~  
131.11 ~~recipient's home and community. Services may also be provided at the home of a relative~~  
131.12 ~~or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,~~  
131.13 ~~or other places in the community. (a) Except for "transition to community services," the~~  
131.14 place of service does not include a regional treatment center, nursing home, residential  
131.15 treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36),  
131.16 or section 245I.23, or an acute care hospital.

131.17 ~~(e) Adult rehabilitative mental health services may be provided in group settings if~~  
131.18 ~~appropriate to each participating recipient's needs and individual treatment plan. A group~~  
131.19 ~~is defined as two to ten clients, at least one of whom is a recipient, who is concurrently~~  
131.20 ~~receiving a service which is identified in this section. The service and group must be specified~~  
131.21 ~~in the recipient's individual treatment plan. (b) No more than two qualified staff may bill~~  
131.22 Medicaid for services provided to the same group of recipients. If two adult rehabilitative  
131.23 mental health workers bill for recipients in the same group session, they must each bill for  
131.24 different recipients.

131.25 ~~(d)~~ (c) Adult rehabilitative mental health services are appropriate if provided to enable  
131.26 a recipient to retain stability and functioning, when the recipient is at risk of significant  
131.27 functional decompensation or requiring more restrictive service settings without these  
131.28 services.

131.29 ~~(e) Adult rehabilitative mental health services instruct, assist, and support the recipient~~  
131.30 ~~in areas including: interpersonal communication skills, community resource utilization and~~  
131.31 ~~integration skills, crisis planning, relapse prevention skills, health care directives, budgeting~~  
131.32 ~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,~~  
131.33 ~~transportation skills, medication education and monitoring, mental illness symptom~~

132.1 ~~management skills, household management skills, employment-related skills, parenting~~  
132.2 ~~skills, and transition to community living services.~~

132.3 ~~(f) Community intervention, including consultation with relatives, guardians, friends,~~  
132.4 ~~employers, treatment providers, and other significant individuals, is appropriate when~~  
132.5 ~~directed exclusively to the treatment of the client.~~

132.6 **EFFECTIVE DATE.** This section is effective January 1, 2028.

132.7 Sec. 38. Minnesota Statutes 2024, section 256B.0624, subdivision 1, is amended to read:

132.8 Subdivision 1. **Scope.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically  
132.9 necessary crisis response services when the services are provided according to the standards  
132.10 in ~~this section~~ 245I.24.

132.11 (b) ~~Subject to federal approval,~~ Medical assistance covers medically necessary residential  
132.12 crisis stabilization for adults when the services are provided by an entity licensed under and  
132.13 meeting the standards in section 245I.23 or an entity with an adult foster care license meeting  
132.14 the standards in ~~this section~~ subdivision 7a.

132.15 (c) The provider entity must make reasonable and good faith efforts to report individual  
132.16 client outcomes to the commissioner using instruments and protocols approved by the  
132.17 commissioner.

132.18 **EFFECTIVE DATE.** This section is effective January 1, 2028.

132.19 Sec. 39. Minnesota Statutes 2024, section 256B.0624, subdivision 4, is amended to read:

132.20 Subd. 4. **Provider entity standards.** (a) A mobile crisis provider must be:

132.21 (1) a county board operated entity;

132.22 (2) an Indian health services facility or facility owned and operated by a tribe or Tribal  
132.23 organization operating under United States Code, title 325, section 450f; or

132.24 (3) a provider entity that is under contract with the county board in the county where  
132.25 the potential crisis or emergency is occurring. To provide services under this section, the  
132.26 provider entity must directly provide the services; or if services are subcontracted, the  
132.27 provider entity must maintain responsibility for services and billing.

132.28 ~~(b) A mobile crisis provider must meet the following standards:~~

132.29 ~~(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are~~  
132.30 ~~available to a recipient 24 hours a day, seven days a week;~~

133.1 ~~(2) be able to respond to a call for services in a designated service area or according to~~  
133.2 ~~a written agreement with the local mental health authority for an adjacent area;~~

133.3 ~~(3) have at least one mental health professional on staff at all times and at least one~~  
133.4 ~~additional staff member capable of leading a crisis response in the community; and~~

133.5 ~~(4) provide the commissioner with information about the number of requests for service,~~  
133.6 ~~the number of people that the provider serves face-to-face, outcomes, and the protocols that~~  
133.7 ~~the provider uses when deciding when to respond in the community.~~

133.8 ~~(e) A provider entity that provides crisis stabilization services in a residential setting~~  
133.9 ~~under subdivision 7 is not required to meet the requirements of paragraphs (a) and (b), but~~  
133.10 ~~must meet all other requirements of this subdivision.~~

133.11 ~~(d) A crisis services provider must have the capacity to meet and carry out the standards~~  
133.12 ~~in section 245I.011, subdivision 5, and the following standards:~~

133.13 ~~(1) ensures that staff persons provide support for a recipient's family and natural supports,~~  
133.14 ~~by enabling the recipient's family and natural supports to observe and participate in the~~  
133.15 ~~recipient's treatment, assessments, and planning services;~~

133.16 ~~(2) has adequate administrative ability to ensure availability of services;~~

133.17 ~~(3) is able to ensure that staff providing these services are skilled in the delivery of~~  
133.18 ~~mental health crisis response services to recipients;~~

133.19 ~~(4) is able to ensure that staff are implementing culturally specific treatment identified~~  
133.20 ~~in the crisis treatment plan that is meaningful and appropriate as determined by the recipient's~~  
133.21 ~~culture, beliefs, values, and language;~~

133.22 ~~(5) is able to ensure enough flexibility to respond to the changing intervention and care~~  
133.23 ~~needs of a recipient as identified by the recipient or family member during the service~~  
133.24 ~~partnership between the recipient and providers;~~

133.25 ~~(6) is able to ensure that staff have the communication tools and procedures to~~  
133.26 ~~communicate and consult promptly about crisis assessment and interventions as services~~  
133.27 ~~occur;~~

133.28 ~~(7) is able to coordinate these services with county emergency services, community~~  
133.29 ~~hospitals, ambulance, transportation services, social services, law enforcement, engagement~~  
133.30 ~~services, and mental health crisis services through regularly scheduled interagency meetings;~~

133.31 ~~(8) is able to ensure that services are coordinated with other behavioral health service~~  
133.32 ~~providers, county mental health authorities, or federally recognized American Indian~~

134.1 ~~authorities and others as necessary, with the consent of the recipient or parent or guardian.~~  
134.2 ~~Services must also be coordinated with the recipient's case manager if the recipient is~~  
134.3 ~~receiving case management services;~~

134.4 ~~(9) is able to ensure that crisis intervention services are provided in a manner consistent~~  
134.5 ~~with sections 245.461 to 245.486 and 245.487 to 245.487;~~

134.6 ~~(10) is able to coordinate detoxification services for the recipient according to Minnesota~~  
134.7 ~~Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;~~

134.8 ~~(11) is able to establish and maintain a quality assurance and evaluation plan to evaluate~~  
134.9 ~~the outcomes of services and recipient satisfaction; and~~

134.10 ~~(12) is an enrolled medical assistance provider.~~

134.11 (b) A mobile crisis provider must ensure services are provided consistent with section  
134.12 245.469, subdivisions 1 and 2.

134.13 **EFFECTIVE DATE.** This section is effective January 1, 2028.

134.14 Sec. 40. Minnesota Statutes 2024, section 256B.0624, is amended by adding a subdivision  
134.15 to read:

134.16 Subd. 7a. **Residential crisis stabilization services in adult foster care settings.** (a) If  
134.17 crisis stabilization services are provided in a supervised, licensed residential setting that  
134.18 serves no more than four adult residents, and one or more individuals are present at the  
134.19 setting to receive residential crisis stabilization, the residential setting staff must include,  
134.20 for at least eight hours per day, at least one mental health professional, clinical trainee,  
134.21 certified rehabilitation specialist, or mental health practitioner.

134.22 (b) The commissioner must establish a statewide per diem rate for crisis stabilization  
134.23 services provided under this paragraph to medical assistance enrollees. The rate for a provider  
134.24 must not exceed the rate charged by that provider for the same service to other payers.  
134.25 Payment must not be made to more than one entity for each individual for services provided  
134.26 under this paragraph on a given day. The commissioner must set rates prospectively for the  
134.27 annual rate period. The commissioner must require providers to submit annual cost reports  
134.28 on a uniform cost reporting form and use submitted cost reports to inform the rate-setting  
134.29 process. The commissioner must recalculate the statewide per diem every year.

134.30 (c) A provider under this subdivision must follow the requirements under section 245I.24,  
134.31 subdivisions 4, paragraphs (c) and (d), and 9.

134.32 **EFFECTIVE DATE.** This section is effective January 1, 2028.

135.1 Sec. 41. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, is  
135.2 amended to read:

135.3 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical  
135.4 assistance covers services provided by a not-for-profit certified community behavioral health  
135.5 clinic (CCBHC) that meets the requirements of section ~~245.735, subdivision 3~~ 245I.17.

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

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

135.14 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each  
135.15 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable  
135.16 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the  
135.17 payment rate, total annual visits include visits covered by medical assistance and visits not  
135.18 covered by medical assistance. Allowable costs include but are not limited to the salaries  
135.19 and benefits of medical assistance providers; the cost of CCBHC services provided under  
135.20 section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245I.17, subdivision 4;  
135.21 and other costs such as insurance or supplies needed to provide CCBHC services;

135.22 (2) payment shall be limited to one payment per day per medical assistance enrollee  
135.23 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement  
135.24 if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph~~  
135.25 ~~(a), clause (6)~~ 245I.17, subdivision 4, is furnished to a medical assistance enrollee by a  
135.26 health care practitioner or licensed agency employed by or under contract with a CCBHC;

135.27 (3) initial CCBHC daily bundled rates for newly ~~certified~~ licensed CCBHCs under  
135.28 section ~~245.735, subdivision 3~~ 245I.17, shall be established by the commissioner using a  
135.29 provider-specific rate based on the newly ~~certified~~ licensed CCBHC's audited historical  
135.30 cost report data adjusted for the expected cost of delivering CCBHC services. Estimates  
135.31 are subject to review by the commissioner and must include the expected cost of providing  
135.32 the full scope of CCBHC services and the expected number of visits for the rate period;

135.33 (4) the commissioner shall rebase CCBHC rates once every two years following the last  
135.34 rebasing and no less than 12 months following an initial rate or a rate change due to a change

136.1 in the scope of services. For CCBHCs certified after September 30, 2020, and before January  
136.2 1, 2021, the commissioner shall rebase rates according to this clause for services provided  
136.3 on or after January 1, 2024;

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

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

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

136.14 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each  
136.15 provider-specific rate by the Medicare Economic Index for primary care services. This  
136.16 update shall occur each year in between rebasing periods determined by the commissioner  
136.17 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state  
136.18 annually using the CCBHC cost report established by the commissioner; and

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

136.27 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC  
136.28 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of  
136.29 this requirement on the rate of access to the services delivered by CCBHC providers. If, for  
136.30 any contract year, federal approval is not received for this paragraph, the commissioner  
136.31 must adjust the capitation rates paid to managed care plans and county-based purchasing  
136.32 plans for that contract year to reflect the removal of this provision. Contracts between  
136.33 managed care plans and county-based purchasing plans and providers to whom this paragraph  
136.34 applies must allow recovery of payments from those providers if capitation rates are adjusted

137.1 in accordance with this paragraph. Payment recoveries must not exceed the amount equal  
137.2 to any increase in rates that results from this provision. This paragraph expires if federal  
137.3 approval is not received for this paragraph at any time.

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

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

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

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

137.14 (4) a CCBHC must provide the commissioner with data needed to determine incentive  
137.15 payment eligibility within six months following the measurement year. The commissioner  
137.16 shall notify CCBHC providers of their performance on the required measures and the  
137.17 incentive payment amount within 12 months following the measurement year.

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

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

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

137.28 If the conditions in this paragraph are met between January 1 and June 30 of a calendar  
137.29 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of  
137.30 the following year. If the conditions in this paragraph are met between July 1 and December  
137.31 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning  
137.32 on July 1 of the following year.

138.1 (g) Peer services provided by a CCBHC ~~certified~~ licensed under section ~~245.735~~ 245I.17  
138.2 are a covered service under medical assistance when a licensed mental health professional  
138.3 or alcohol and drug counselor determines that peer services are medically necessary.  
138.4 Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility  
138.5 standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph  
138.6 (b), clause (2).

138.7 **EFFECTIVE DATE.** This section is effective January 1, 2028.

138.8 Sec. 42. Minnesota Statutes 2024, section 256B.0943, subdivision 2, is amended to read:

138.9 Subd. 2. **Covered service components of children's therapeutic services and**  
138.10 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary  
138.11 children's therapeutic services and supports when the services are provided by an eligible  
138.12 provider entity ~~certified under and meeting the standards in this section~~ licensed under  
138.13 section 245I.30 or children's day treatment services licensed under section 245I.31. The  
138.14 provider entity must make reasonable and good faith efforts to report individual client  
138.15 outcomes to the commissioner, using instruments and protocols approved by the  
138.16 commissioner.

138.17 (b) The covered service components of children's therapeutic services and supports are:

138.18 ~~(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,~~  
138.19 ~~and group psychotherapy;~~

138.20 ~~(2) individual, family, or group skills training provided by a mental health professional,~~  
138.21 ~~clinical trainee, or mental health practitioner;~~

138.22 ~~(3) crisis planning;~~

138.23 ~~(4) mental health behavioral aide services;~~

138.24 (1) the services described in section 245I.30, subdivision 2, provided by providers  
138.25 licensed under section 245I.30 or 245I.31;

138.26 (2) administration of standardized measures;

138.27 ~~(5)~~ (3) direction of a mental health behavioral aide; and

138.28 ~~(6)~~ (4) mental health service plan development; and

138.29 ~~(7) children's day treatment.~~

138.30 (c) In delivering services under this section, a licensed provider entity must ensure that  
138.31 psychotherapy to address a child's underlying mental health disorder is documented as part

139.1 of the child's ongoing treatment. A provider must deliver or arrange for medically necessary  
 139.2 psychotherapy unless the child's parent or caregiver chooses not to receive the psychotherapy  
 139.3 or the provider determines that psychotherapy is no longer medically necessary. When a  
 139.4 provider determines that psychotherapy is no longer medically necessary, the provider must  
 139.5 update required documentation, including but not limited to the individual treatment plan,  
 139.6 the child's medical record, or other authorizations, to include the determination. When a  
 139.7 provider determines that a child needs psychotherapy but psychotherapy cannot be delivered  
 139.8 due to a shortage of licensed mental health professionals in the child's community, the  
 139.9 provider must document the lack of access in the child's medical record.

139.10 (d) Medical assistance covers service plan development before completion of a child's  
 139.11 individual treatment plan. Service plan development consists of development, review, and  
 139.12 revision of the individual treatment plan by face-to-face or electronic communication,  
 139.13 including time spent gathering client history from other key figures or providers. The provider  
 139.14 must document events, including the time spent with the family and other key participants  
 139.15 in the child's life to approve the individual treatment plan. Service plan development is  
 139.16 covered only if a treatment plan is completed or for work already completed at the time the  
 139.17 client voluntarily chooses to disengage with services for the child. If it is determined upon  
 139.18 review that a treatment plan was not completed for the child, the commissioner shall recover  
 139.19 the payment for the service plan development.

139.20 (e) Medical assistance covers time spent administering and reporting standardized  
 139.21 measures approved by the commissioner.

139.22 **EFFECTIVE DATE.** This section is effective January 1, 2028.

139.23 Sec. 43. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 3, is  
 139.24 amended to read:

139.25 Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's  
 139.26 therapeutic services and supports under this section shall be determined based on a standard  
 139.27 diagnostic assessment by a mental health professional or a clinical trainee that is performed  
 139.28 within one year before the initial start of service and updated as required under section  
 139.29 245I.10, subdivision 2. The standard diagnostic assessment must:

139.30 (1) ~~determine whether a child under age 18 has a diagnosis of mental illness or, if the~~  
 139.31 ~~person is between the ages of 18 and 21, whether~~ the person has a mental illness; and

140.1 (2) document children's therapeutic services and supports as medically necessary to  
140.2 address an identified disability, functional impairment, and the individual client's needs and  
140.3 goals; ~~and~~.

140.4 ~~(3) be used in the development of the individual treatment plan.~~

140.5 (b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to  
140.6 five days of day treatment under this section based on a hospital's medical history and  
140.7 presentation examination of the client.

140.8 ~~(c) Children's therapeutic services and supports include development and rehabilitative~~  
140.9 ~~services that support a child's developmental treatment needs.~~

140.10 Sec. 44. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 12, is  
140.11 amended to read:

140.12 Subd. 12. **Excluded services.** (a) The following services are not eligible for medical  
140.13 assistance payment as children's therapeutic services and supports:

140.14 (1) service components of children's therapeutic services and supports simultaneously  
140.15 provided by more than one provider entity unless prior authorization is obtained;

140.16 (2) treatment by multiple providers within the same agency at the same clock time,  
140.17 unless one service is delivered to the child and the other service is delivered to the child's  
140.18 family or treatment team without the child present;

140.19 (3) children's therapeutic services and supports provided in violation of medical assistance  
140.20 policy in Minnesota Rules, part 9505.0220;

140.21 (4) mental health behavioral aide services provided by a personal care assistant who is  
140.22 not qualified as a mental health behavioral aide and employed by a certified children's  
140.23 therapeutic services and supports provider entity;

140.24 (5) service components of CTSS that are the responsibility of a residential or program  
140.25 license holder, including foster care providers under the terms of a service agreement or  
140.26 administrative rules governing licensure; and

140.27 (6) adjunctive activities that may be offered by a provider entity but are not otherwise  
140.28 covered by medical assistance, including:

140.29 (i) a service that is primarily recreation oriented or that is provided in a setting that is  
140.30 not medically supervised. This includes sports activities, exercise groups, activities such as  
140.31 craft hours, leisure time, social hours, meal or snack time, trips to community activities,  
140.32 and tours;

141.1 (ii) a social or educational service that does not have or cannot reasonably be expected  
141.2 to have a therapeutic outcome related to the client's mental illness;

141.3 (iii) prevention or education programs provided to the community; and

141.4 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

141.5 (b) Time spent on administrative tasks before and after providing direct services, including  
141.6 scheduling or maintaining clinical records, is included in CTSS payments and may not be  
141.7 separately billed as additional clock hours of service.

141.8 Sec. 45. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended  
141.9 to read:

141.10 Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency  
141.11 responsible for investigating allegations of maltreatment in child foster care, family child  
141.12 care, legally nonlicensed child care, and reports involving children served by an unlicensed  
141.13 personal care provider organization under section 256B.0659. Copies of findings related to  
141.14 personal care provider organizations under section 256B.0659 must be forwarded to the  
141.15 Department of Human Services provider enrollment.

141.16 (b) The Department of Human Services is the agency responsible for screening and  
141.17 investigating allegations of maltreatment in juvenile correctional facilities listed under  
141.18 section 241.021 located in the local welfare agency's county and in facilities licensed or  
141.19 certified under chapters 245A and 245D.

141.20 (c) The Department of Health is the agency responsible for screening and investigating  
141.21 allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43  
141.22 to 144A.482 or chapter 144H.

141.23 (d) The Department of Education is the agency responsible for screening and investigating  
141.24 allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11,  
141.25 and 13, and chapter 124E. The Department of Education's responsibility to screen and  
141.26 investigate includes allegations of maltreatment involving students 18 through 21 years of  
141.27 age, including students receiving special education services, up to and including graduation  
141.28 and the issuance of a secondary or high school diploma.

141.29 (e) The Department of Human Services is the agency responsible for screening and  
141.30 investigating allegations of maltreatment of minors in an EIDBI agency operating under  
141.31 sections 245A.142 and 256B.0949.

142.1 (f) A health or corrections agency receiving a report may request the local welfare agency  
142.2 to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

142.3 (g) The Department of Children, Youth, and Families is the agency responsible for  
142.4 screening and investigating allegations of maltreatment in facilities or programs not listed  
142.5 in paragraph (a) that are licensed or certified under chapters 142B and 142C.

142.6 (h) The Department of Human Services is the agency responsible for screening and  
142.7 investigating allegations of maltreatment of minors for mobile crisis response services and  
142.8 children's therapeutic services and supports programs licensed under chapter 245I.

142.9 Sec. 46. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended  
142.10 to read:

142.11 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary  
142.12 administrative agency responsible for investigating reports made under section 626.557.

142.13 (a) The Department of Health is the lead investigative agency for facilities or services  
142.14 licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding  
142.15 care homes, hospice providers, residential facilities that are also federally certified as  
142.16 intermediate care facilities that serve people with developmental disabilities, or any other  
142.17 facility or service not listed in this subdivision that is licensed or required to be licensed by  
142.18 the Department of Health for the care of vulnerable adults. "Home care provider" has the  
142.19 meaning provided in section 144A.43, subdivision 4, and applies when care or services are  
142.20 delivered in the vulnerable adult's home.

142.21 (b) The Department of Human Services is the lead investigative agency for facilities or  
142.22 services licensed or required to be licensed as adult day care, adult foster care, community  
142.23 residential settings, programs for people with disabilities, EIDBI agencies, family adult day  
142.24 services, mental health programs licensed under chapter 245I, mental health clinics, substance  
142.25 use disorder programs, the Minnesota Sex Offender Program, or any other facility or service  
142.26 not listed in this subdivision that is licensed or required to be licensed by the Department  
142.27 of Human Services. The Department of Human Services is also the lead investigative agency  
142.28 for unlicensed EIDBI agencies under section 256B.0949. The Department of Human Services  
142.29 is the lead investigative agency for adult rehabilitative mental health services under section  
142.30 245I.22, mobile crisis response services under section 245I.24, and certified community  
142.31 behavioral health clinics under section 245I.17.

143.1 (c) The county social service agency or its designee is the lead investigative agency for  
143.2 all other reports, including but not limited to reports involving vulnerable adults receiving  
143.3 services from a personal care provider organization under section 256B.0659.

143.4 **EFFECTIVE DATE.** This section is effective January 1, 2028.

143.5 Sec. 47. **REVISOR INSTRUCTION.**

143.6 The revisor of statutes shall renumber Minnesota Statutes, section 245.735, subdivisions  
143.7 5 and 6, as Minnesota Statutes, section 245I.17, subdivisions 23 and 24.

143.8 Sec. 48. **REPEALER.**

143.9 (a) Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e,  
143.10 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, and 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23,  
143.11 subdivision 23; 256B.0623, subdivisions 2, 4, 5, 6, and 9; 256B.0624, subdivisions 2, 3,  
143.12 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11; and 256B.0943, subdivisions 4, 5, 5a, 6, 7, and 11, are  
143.13 repealed.

143.14 (b) Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3 and 4d; and  
143.15 256B.0943, subdivisions 1 and 9, are repealed.

143.16 **EFFECTIVE DATE.** This section is effective January 1, 2028.

143.17

## ARTICLE 5

143.18

### AGING AND DISABILITY SERVICES

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

143.20 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license  
143.21 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, which  
143.22 does not include child foster residence settings with residential program certifications for  
143.23 compliance with the Family First Prevention Services Act under section 245A.25, subdivision  
143.24 1, paragraph (a), or adult foster care licensed under Minnesota Rules, parts 9555.5105 to  
143.25 9555.6265, under this chapter for a physical location that will not be the primary residence  
143.26 of the license holder for the entire period of licensure. If a child foster residence setting that  
143.27 was previously exempt from the licensing moratorium under this paragraph has its Family  
143.28 First Prevention Services Act certification rescinded under section 245A.25, subdivision 9,  
143.29 or if a family adult foster care home license is issued during this moratorium, and the license  
143.30 holder changes the license holder's primary residence away from the physical location of  
143.31 the foster care license, the commissioner shall revoke the license according to section

144.1 245A.07. The commissioner shall not issue an initial license for a community residential  
144.2 setting licensed under chapter 245D. When approving an exception under this paragraph,  
144.3 the commissioner shall consider the resource need determination process in paragraph (h),  
144.4 the availability of foster care licensed beds in the geographic area in which the licensee  
144.5 seeks to operate, the results of a person's choices during their annual assessment and service  
144.6 plan review, and the recommendation of the local county board. The determination by the  
144.7 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

144.10 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or  
144.11 community residential setting licenses replacing adult foster care licenses in existence on  
144.12 December 31, 2013, and determined to be needed by the commissioner under paragraph  
144.13 (b);

144.14 (3) new foster care licenses or community residential setting licenses determined to be  
144.15 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,  
144.16 or regional treatment center; restructuring of state-operated services that limits the capacity  
144.17 of state-operated facilities; or allowing movement to the community for people who no  
144.18 longer require the level of care provided in state-operated facilities as provided under section  
144.19 256B.092, subdivision 13, or 256B.49, subdivision 24;

144.20 (4) new foster care licenses or community residential setting licenses determined to be  
144.21 needed by the commissioner under paragraph (b) for persons requiring hospital-level care;  
144.22 or

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

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

144.33 (c) When an adult resident served by the program moves out of a foster home that is not  
144.34 the primary residence of the license holder according to section 256B.49, subdivision 15,

145.1 paragraph (f), or the adult community residential setting, the county shall immediately  
145.2 inform the Department of Human Services Licensing Division. The department may decrease  
145.3 the statewide licensed capacity for adult foster care settings.

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

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

145.18 (f) At the time of application and reapplication for licensure, the applicant and the license  
145.19 holder that are subject to the moratorium or an exclusion established in paragraph (a) are  
145.20 required to inform the commissioner whether the physical location where the foster care  
145.21 will be provided is or will be the primary residence of the license holder for the entire period  
145.22 of licensure. If the primary residence of the applicant or license holder changes, the applicant  
145.23 or license holder must notify the commissioner immediately. The commissioner shall print  
145.24 on the foster care license certificate whether or not the physical location is the primary  
145.25 residence of the license holder.

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

145.32 (h) The commissioner may adjust capacity to address needs identified in section  
145.33 144A.351. Under this authority, the commissioner may approve new licensed settings or

146.1 delicense existing settings. Delicensing of settings will be accomplished through a process  
146.2 identified in section 256B.493.

146.3 (i) The commissioner must notify a license holder when its corporate foster care or  
146.4 community residential setting licensed beds are reduced under this section. The notice of  
146.5 reduction of licensed beds must be in writing and delivered to the license holder by certified  
146.6 mail or personal service. The notice must state why the licensed beds are reduced and must  
146.7 inform the license holder of its right to request reconsideration by the commissioner. The  
146.8 license holder's request for reconsideration must be in writing. If mailed, the request for  
146.9 reconsideration must be postmarked and sent to the commissioner within 20 calendar days  
146.10 after the license holder's receipt of the notice of reduction of licensed beds. If a request for  
146.11 reconsideration is made by personal service, it must be received by the commissioner within  
146.12 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

146.22 (k) Except as permitted in this paragraph, the commissioner must not issue an initial  
146.23 license under chapter 245D authorizing integrated community supports under section  
146.24 245D.03, subdivision 1, paragraph (c), clause (8), and must not approve a license change  
146.25 adding integrated community supports to an existing license under chapter 245D. The  
146.26 commissioner may approve an exception to the moratorium only when the applicant or  
146.27 licensee meets all requirements under section 245D.12, the request is not superseded by  
146.28 temporary moratoriums under section 245A.03, subdivision 7a, and the applicant submits  
146.29 documentation demonstrating compliance with:

146.30 (1) federal and state home and community-based services requirements for  
146.31 provider-controlled settings;

146.32 (2) the prohibition on the use of Medicaid money for room and board under section  
146.33 256B.4912, subdivision 17, including the requirement that the provider not pay, subsidize,  
146.34 offset, or otherwise financially contribute to rent, utilities, or other housing costs; and

147.1 (3) all licensing requirements applicable to integrated community supports under chapter  
147.2 245D.

147.3 In determining whether to approve an exception, the commissioner must consider statewide  
147.4 and regional capacity for integrated community supports based on needs-determination  
147.5 processes under paragraph (e). Nothing in this paragraph authorizes the commissioner to  
147.6 deny a change of ownership license, a temporary change of ownership license, or a temporary  
147.7 transitional license that is otherwise permissible under section 245A.043. A determination  
147.8 under this paragraph is final and not subject to appeal.

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

147.10 Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 7a, is amended  
147.11 to read:

147.12 Subd. 7a. **Discretionary temporary licensing moratorium.** (a) The commissioner must  
147.13 not accept an application from or issue an initial license for an individual, organization, or  
147.14 government entity seeking licensure under this chapter and must not add a new service to  
147.15 an existing license when the commissioner determines that exceptional growth in applications  
147.16 for licensure or requests to add new services exceeds the determined need for service  
147.17 capacity. The determined need for service capacity may be limited to a specific region,  
147.18 service focus, or other factors as determined by the commissioner. A temporary licensing  
147.19 moratorium issued under this subdivision is effective for a period of up to 24 months from  
147.20 the date the commissioner issues the moratorium.

147.21 (b) Any applicant that will not receive a license due to a temporary licensing moratorium  
147.22 issued under paragraph (a) may apply for a refund of licensing application fees for up to  
147.23 one year from the date the commissioner issues the moratorium.

147.24 (c) The commissioner must notify the chairs and ranking minority members of the  
147.25 legislative committees with jurisdiction over health and human services at least 30 days  
147.26 prior to issuing a temporary moratorium under this subdivision and publish notice of the  
147.27 moratorium on the department's website. The notice must include:

147.28 (1) a list of all license types to which the moratorium will apply;

147.29 (2) the proposed start date of the moratorium; and

147.30 (3) the anticipated duration of the moratorium.

148.1 (d) The commissioner must establish and make publicly available the processes and  
148.2 criteria the commissioner will use to grant exceptions to a temporary moratorium issued  
148.3 under this subdivision.

148.4 (e) Nothing in this subdivision authorizes the commissioner to deny a change of  
148.5 ownership license, a temporary change of ownership license, or a temporary transitional  
148.6 license that is otherwise permissible under section 245A.043.

148.7 Sec. 3. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 7a, is amended  
148.8 to read:

148.9 Subd. 7a. **Discretionary temporary licensing moratorium.** (a) The commissioner must  
148.10 not accept an application from or issue an initial license for an individual, organization, or  
148.11 government entity seeking licensure under this chapter and must not add a new service to  
148.12 an existing license when the commissioner determines based on documented and publicly  
148.13 available data that exceptional growth in applications for licensure or requests to add new  
148.14 services materially exceeds the determined need for service capacity. The determined need  
148.15 for service capacity may be limited to a specific region, service focus, or other factors as  
148.16 determined by the commissioner. A temporary licensing moratorium issued under this  
148.17 subdivision is effective for a period of up to 24 months from the date the commissioner  
148.18 issues the moratorium.

148.19 ~~(b) Any applicant that will not receive a license due to a temporary licensing moratorium~~  
148.20 ~~issued under paragraph (a) may apply for a refund of licensing application fees for up to~~  
148.21 ~~one year from the date the commissioner issues the moratorium.~~

148.22 ~~(e) The commissioner must notify the chairs and ranking minority members of the~~  
148.23 ~~legislative committees with jurisdiction over health and human services at least 30 days~~  
148.24 ~~prior to issuing a temporary moratorium under this subdivision and publish notice of the~~  
148.25 ~~moratorium on the department's website. The notice must include:~~

148.26 ~~(1) a list of all license types to which the moratorium will apply;~~

148.27 ~~(2) the proposed start date of the moratorium; and~~

148.28 ~~(3) the anticipated duration of the moratorium.~~

148.29 ~~(d) The commissioner must establish and make publicly available the processes and~~  
148.30 ~~criteria the commissioner will use to grant exceptions to a temporary moratorium issued~~  
148.31 ~~under this subdivision.~~

149.1 (b) For purposes of this subdivision, a determination of exceptional growth in applications  
149.2 for licensure or requests to add new services must be supported by:

149.3 (1) a comparative analysis of application growth over at least the prior three fiscal years;

149.4 (2) current service utilization and waiver enrollment data;

149.5 (3) projected enrollment trends; and

149.6 (4) a regional service capacity analysis.

149.7 (c) When determining the need for service capacity under this subdivision, the  
149.8 commissioner must document consideration of:

149.9 (1) geographic distribution of providers;

149.10 (2) accessibility for individuals with disabilities;

149.11 (3) language access and culturally specific service availability;

149.12 (4) rural and Tribal community access; and

149.13 (5) the capacity of providers to serve high-acuity or specialized populations.

149.14 (d) The determined need for service capacity must be limited to a specific region, service  
149.15 focus, or other factors as determined by the commissioner. The commissioner's determination  
149.16 that the statewide service capacity exceeds the statewide need is insufficient to support  
149.17 issuance of a moratorium under this subdivision.

149.18 (e) Prior to implementing a moratorium under this subdivision, the commissioner must:

149.19 (1) prepare written findings explaining the data and methodology used to determine  
149.20 excess capacity;

149.21 (2) document the access considerations required under this subdivision; and

149.22 (3) provide the written findings to the chairs and ranking minority members of the  
149.23 legislative committees with jurisdiction over health and human services at least 45 days

149.24 prior to implementing the moratorium and publish notice on the department's website and  
149.25 in the State Register. The notice must include:

149.26 (i) a list of all license types to which the moratorium will apply;

149.27 (ii) the proposed start date;

149.28 (iii) the anticipated duration;

149.29 (iv) a summary of the data supporting the determination; and

150.1 (v) a description of the publicly available exception process under subdivision 7c.

150.2 (f) A temporary licensing moratorium issued under this subdivision is effective for a  
150.3 period of up to 24 months from the date the commissioner issues the moratorium.

150.4 (g) Notwithstanding paragraph (a), the commissioner may issue or modify a temporary  
150.5 licensing moratorium under this subdivision when required by a written directive, corrective  
150.6 action plan, waiver condition, or enforcement action issued by the Centers for Medicare  
150.7 and Medicaid Services (CMS). Prior to issuing a moratorium under this paragraph, the  
150.8 commissioner must:

150.9 (1) publish the CMS directive or correspondence necessitating the action;

150.10 (2) certify that the moratorium is narrowly tailored to address only the federally identified  
150.11 issue; and

150.12 (3) limit the duration to the minimum period necessary to achieve federal compliance.

150.13 A moratorium issued under this paragraph remains subject to the reporting requirements  
150.14 under subdivision 7c.

150.15 (h) Nothing in this subdivision authorizes the commissioner to deny a change of  
150.16 ownership license, a temporary change of ownership license, or a temporary transitional  
150.17 license that is otherwise permissible under section 245A.043.

150.18 Sec. 4. Minnesota Statutes 2024, section 245A.03, is amended by adding a subdivision to  
150.19 read:

150.20 Subd. 7b. **Refunds following implementation of a moratorium.** Any applicant that  
150.21 will not receive a license due to a temporary licensing moratorium issued under subdivision  
150.22 7a may apply for a refund of licensing application fees for up to one year from the date the  
150.23 commissioner issues the moratorium.

150.24 Sec. 5. Minnesota Statutes 2024, section 245A.03, is amended by adding a subdivision to  
150.25 read:

150.26 Subd. 7c. **Publicly available exception process and ongoing reporting.** (a) The  
150.27 commissioner must establish and make publicly available an explanation of the processes  
150.28 and criteria the commissioner will use to grant exceptions to a temporary moratorium issued  
150.29 under subdivision 7a. The publicly available explanation must include:

150.30 (1) standardized submission requirements to which lead agencies must comply;

150.31 (2) objective exception evaluation criteria; and

151.1 (3) defined timelines for decision-making.

151.2 (b) During any period in which a moratorium under subdivision 7a is in effect, the  
151.3 commissioner must submit a report every 12 months to the chairs and ranking minority  
151.4 members of the legislative committees with jurisdiction over human services. The report  
151.5 must include:

151.6 (1) the number of applications received for a license subject to the moratorium;

151.7 (2) the number of applications rejected due to the moratorium;

151.8 (3) the number of exception requests received, approved, and denied;

151.9 (4) the geographic distribution of exception requests; and

151.10 (5) an updated analysis of service capacity and utilization.

151.11 Sec. 6. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision  
151.12 to read:

151.13 **Subd. 7. Department of Human Services home and community-based services early**  
151.14 **and often licensor and compliance team.** (a) The commissioner must establish and maintain  
151.15 a home and community-based services early and often licensor and compliance team to  
151.16 deliver proactive and coordinated support to applicants through the application process and  
151.17 to license holders during the first year of operation of the licensed home and  
151.18 community-based program. The commissioner must ensure that the home and  
151.19 community-based services early and often licensor and compliance team has sufficient staff  
151.20 and resources to perform the functions required under this subdivision. The commissioner  
151.21 must ensure that the licensor and compliance team has members with expertise in licensing  
151.22 requirements and members with expertise in medical assistance enrollment requirements,  
151.23 medical assistance service delivery requirements, and medical assistance billing requirements.

151.24 (b) The home and community-based services early and often licensor and compliance  
151.25 team must provide technical assistance to applicants regarding completing and submitting  
151.26 license applications under this chapter and chapter 256D and medical assistance provider  
151.27 enrollment applications under section 256B.04, subdivision 21.

151.28 (c) The home and community-based services early and often licensor and compliance  
151.29 team must conduct an initial scheduled technical assistance visit three months after the  
151.30 effective date of an initial license for the purpose of providing technical assistance to the  
151.31 license holder. The team must provide technical assistance related to achieving and  
151.32 maintaining compliance with the applicable laws, rules, and regulations governing the

152.1 provision of and reimbursement for home and community-based services under this chapter  
152.2 and chapters 245D, 256B, and 256S and waiver plans.

152.3 (d) The home and community-based services early and often licensor and compliance  
152.4 team must conduct three unscheduled visits after the beginning of the sixth calendar month  
152.5 following the effective date of an initial license and before the end of the eighteenth month  
152.6 following the effective date of an initial license.

152.7 (e) If during the technical assistance visit or during the following three unannounced  
152.8 visits, the team finds that the license holder has failed to achieve compliance with an  
152.9 applicable law, rule, or regulation, and the failure does not imminently endanger the health,  
152.10 safety, or rights of persons served by the program, the team may issue a licensing and  
152.11 compliance review report with recommendations for achieving and maintaining compliance.

152.12 (f) Nothing in this subdivision shall be construed to limit the commissioner's authority  
152.13 to:

152.14 (1) suspend or revoke a license or issue a fine at any time under section 245A.07 or issue  
152.15 correction orders and make a license conditional for failure to comply with applicable laws,  
152.16 rules, or regulations under section 245A.06 based on the nature, chronicity, or severity of  
152.17 the violation of a law, rule, or regulation and the effect of the violation on the health, safety,  
152.18 or rights of persons served by the program; or

152.19 (2) impose a sanction under section 256B.064 based on the nature, chronicity, or severity  
152.20 of the violation of law, rule, or regulation.

152.21 Sec. 7. Minnesota Statutes 2024, section 245D.261, subdivision 3, is amended to read:

152.22 Subd. 3. **Provider requirements for remote overnight supervision; commissioner**  
152.23 **notification.** (a) A license holder providing remote overnight supervision in a community  
152.24 residential setting must:

152.25 (1) use technology;

152.26 (2) notify the commissioner of the community residential setting's intent to use technology  
152.27 in lieu of on-site staff. The notification must:

152.28 (i) indicate a start date for the use of technology; and

152.29 (ii) attest that all requirements under this section are met and policies required under  
152.30 subdivision 4 are available upon request;

152.31 (3) clearly state in each person's support plan addendum that the community residential  
152.32 setting is a program without the in-person presence of overnight direct support;

153.1 (4) include with each person's support plan addendum the license holder's protocols for  
153.2 responding to situations that present a serious risk to the health, safety, or rights of residents  
153.3 served by the program; ~~and~~

153.4 (5) include in each person's support plan addendum the person's maximum permissible  
153.5 response time as determined by the person's support team; and

153.6 (6) ensure that any third-party monitoring company the license holder contracts with to  
153.7 provide overnight supervision maintains an appropriate staff ratio to ensure that the maximum  
153.8 permissible response time specified in clause (5) is met.

153.9 (b) Upon being notified via technology that an incident has occurred that jeopardizes  
153.10 the health, safety, or rights of a resident, the license holder must document an evaluation  
153.11 of the need for the physical presence of a staff member and determine whether a physical  
153.12 presence is needed in a time that is less than the maximum permissible response time under  
153.13 paragraph (a), clause (5). If it is determined that a physical presence is needed that requires  
153.14 a response time less than the maximum response time under paragraph (a), clause (5), the  
153.15 plan under subdivision 4, paragraph (a), clause (6), must be deployed.

153.16 (c) A license holder must notify the commissioner if remote overnight supervision  
153.17 technology will no longer be used by the license holder.

153.18 (d) Upon receipt of notification of use of remote overnight supervision or discontinuation  
153.19 of use of remote overnight supervision by a license holder, the commissioner shall notify  
153.20 the county licensing agency and update the license.

153.21 Sec. 8. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to  
153.22 read:

153.23 Subd. 45. Department of Human Services home and community-based services  
153.24 provider support and technical assistance team. The commissioner must establish and  
153.25 maintain a home and community-based services provider support and technical assistance  
153.26 team to deliver proactive and coordinated support to home and community-based services  
153.27 providers. The commissioner must ensure that the home and community-based services  
153.28 provider support and technical assistance team has sufficient staff and resources to perform  
153.29 the functions required under this subdivision. The home and community-based services  
153.30 provider support and technical assistance team must:

153.31 (1) serve as a provider liaison and help desk for providers' technical, regulatory, and  
153.32 operational questions;

154.1 (2) develop training and onboarding materials for home and community-based services  
154.2 providers;

154.3 (3) collect data on home and community-based provider challenges;

154.4 (4) coordinate the functions of the department, including information technology,  
154.5 licensing, provider enrollment, service delivery oversight, and program integrity oversight  
154.6 to clarify program requirements, provider requirements, and service requirements and to  
154.7 support providers with compliance and prevention of fraud; and

154.8 (5) make recommendations to the commissioner regarding changes to the operations of  
154.9 the department or to the design and implementation of home and community-based services  
154.10 that would improve the delivery of services and improve program integrity.

154.11 Sec. 9. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is  
154.12 amended to read:

154.13 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"  
154.14 means motor vehicle transportation provided by a public or private person that serves  
154.15 Minnesota health care program beneficiaries who do not require emergency ambulance  
154.16 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

154.17 (b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means  
154.18 a census-tract based classification system under which a geographical area is determined  
154.19 to be urban, rural, or super rural. This paragraph expires July 1, 2026, for medical assistance  
154.20 fee-for-service and January 1, 2027, for prepaid medical assistance.

154.21 (c) Medical assistance covers medical transportation costs incurred solely for obtaining  
154.22 emergency medical care or transportation costs incurred by eligible persons in obtaining  
154.23 emergency or nonemergency medical care when paid directly to an ambulance company,  
154.24 nonemergency medical transportation company, or other recognized providers of  
154.25 transportation services. Medical transportation must be provided by:

154.26 (1) nonemergency medical transportation providers who meet the requirements of this  
154.27 subdivision;

154.28 (2) ambulances, as defined in section 144E.001, subdivision 2;

154.29 (3) taxicabs that meet the requirements of this subdivision;

154.30 (4) public transportation, within the meaning of "public transportation" as defined in  
154.31 section 174.22, subdivision 7; or

155.1 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,  
155.2 subdivision 1, paragraph (p).

155.3 (d) Medical assistance covers nonemergency medical transportation provided by  
155.4 nonemergency medical transportation providers enrolled in the Minnesota health care  
155.5 programs. All nonemergency medical transportation providers must comply with the  
155.6 operating standards for special transportation service as defined in sections 174.29 to 174.30  
155.7 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the  
155.8 commissioner and reported on the claim as the individual who provided the service. All  
155.9 nonemergency medical transportation providers shall bill for nonemergency medical  
155.10 transportation services in accordance with Minnesota health care programs criteria. Publicly  
155.11 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the  
155.12 requirements outlined in this paragraph. This paragraph expires upon the effective date of  
155.13 paragraph (e).

155.14 (e) Effective January 1, 2027, or upon federal approval, whichever is later, medical  
155.15 assistance covers nonemergency medical transportation provided by nonemergency medical  
155.16 transportation providers enrolled in the Minnesota health care programs. All nonemergency  
155.17 medical transportation providers must comply with the operating standards for special  
155.18 transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter  
155.19 8840, and all drivers must be individually enrolled with the commissioner and reported on  
155.20 the claim as the individual who provided the service. All nonemergency medical  
155.21 transportation providers must bill for nonemergency medical transportation services in  
155.22 accordance with Minnesota health care programs criteria and comply with the requirements  
155.23 of section 256B.073. Publicly operated transit systems, volunteers, and not-for-hire vehicles  
155.24 are exempt from the requirements outlined in this paragraph.

155.25 ~~(e)~~ (f) An organization may be terminated, denied, or suspended from enrollment if:

155.26 (1) the provider has not initiated background studies on the individuals specified in  
155.27 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

155.28 (2) the provider has initiated background studies on the individuals specified in section  
155.29 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

155.30 (i) the commissioner has sent the provider a notice that the individual has been  
155.31 disqualified under section 245C.14; and

155.32 (ii) the individual has not received a disqualification set-aside specific to the special  
155.33 transportation services provider under sections 245C.22 and 245C.23.

156.1 ~~(f)~~ (g) The administrative agency of nonemergency medical transportation must:

156.2 (1) adhere to the policies defined by the commissioner;

156.3 (2) pay nonemergency medical transportation providers for services provided to  
156.4 Minnesota health care programs beneficiaries to obtain covered medical services;

156.5 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled  
156.6 trips, and number of trips by mode; and

156.7 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single  
156.8 administrative structure assessment tool that meets the technical requirements established  
156.9 by the commissioner, reconciles trip information with claims being submitted by providers,  
156.10 and ensures prompt payment for nonemergency medical transportation services. This  
156.11 paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027,  
156.12 for prepaid medical assistance.

156.13 ~~(g)~~ (h) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid  
156.14 medical assistance, the administrative agency of nonemergency medical transportation must:

156.15 (1) adhere to the policies defined by the commissioner;

156.16 (2) pay nonemergency medical transportation providers for services provided to  
156.17 Minnesota health care program beneficiaries to obtain covered medical services; and

156.18 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled  
156.19 trips, and number of trips by mode.

156.20 ~~(h)~~ (i) Until the commissioner implements the single administrative structure and delivery  
156.21 system under subdivision 18e, clients shall obtain their level-of-service certificate from the  
156.22 commissioner or an entity approved by the commissioner that does not dispatch rides for  
156.23 clients using modes of transportation under paragraph ~~(n)~~ (o), clauses (4), (5), (6), and (7).  
156.24 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,  
156.25 2027, for prepaid medical assistance.

156.26 ~~(i)~~ (j) The commissioner may use an order by the recipient's attending physician, advanced  
156.27 practice registered nurse, physician assistant, or a medical or mental health professional to  
156.28 certify that the recipient requires nonemergency medical transportation services.

156.29 Nonemergency medical transportation providers shall perform driver-assisted services for  
156.30 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup  
156.31 at and return to the individual's residence or place of business, assistance with admittance  
156.32 of the individual to the medical facility, and assistance in passenger securement or in securing  
156.33 of wheelchairs, child seats, or stretchers in the vehicle.

157.1        ~~(j)~~ (k) Nonemergency medical transportation providers must take clients to the health  
157.2 care provider using the most direct route, and must not exceed 30 miles for a trip to a primary  
157.3 care provider or 60 miles for a trip to a specialty care provider, unless the client receives  
157.4 authorization from the local agency. This paragraph expires July 1, 2026, for medical  
157.5 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

157.6        ~~(k)~~ (l) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,  
157.7 for prepaid medical assistance, nonemergency medical transportation providers must take  
157.8 clients to the health care provider using the most direct route and must not exceed 30 miles  
157.9 for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless  
157.10 the client receives authorization from the administrator.

157.11       ~~(l)~~ (m) Nonemergency medical transportation providers may not bill for separate base  
157.12 rates for the continuation of a trip beyond the original destination. Nonemergency medical  
157.13 transportation providers must maintain trip logs, which include pickup and drop-off times,  
157.14 signed by the medical provider or client, whichever is deemed most appropriate, attesting  
157.15 to mileage traveled to obtain covered medical services. Clients requesting client mileage  
157.16 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical  
157.17 services.

157.18       ~~(m)~~ (n) The administrative agency shall use the level of service process established by  
157.19 the commissioner to determine the client's most appropriate mode of transportation. If public  
157.20 transit or a certified transportation provider is not available to provide the appropriate service  
157.21 mode for the client, the client may receive a onetime service upgrade.

157.22       ~~(n)~~ (o) The covered modes of transportation are:

157.23        (1) client reimbursement, which includes client mileage reimbursement provided to  
157.24 clients who have their own transportation, or to family or an acquaintance who provides  
157.25 transportation to the client;

157.26        (2) volunteer transport, which includes transportation by volunteers using their own  
157.27 vehicle;

157.28        (3) unassisted transport, which includes transportation provided to a client by a taxicab  
157.29 or public transit. If a taxicab or public transit is not available, the client can receive  
157.30 transportation from another nonemergency medical transportation provider;

157.31        (4) assisted transport, which includes transport provided to clients who require assistance  
157.32 by a nonemergency medical transportation provider;

158.1 (5) lift-equipped/ramp transport, which includes transport provided to a client who is  
158.2 dependent on a device and requires a nonemergency medical transportation provider with  
158.3 a vehicle containing a lift or ramp;

158.4 (6) protected transport, which includes transport provided to a client who has received  
158.5 a prescreening that has deemed other forms of transportation inappropriate and who requires  
158.6 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety  
158.7 locks, a video recorder, and a transparent thermoplastic partition between the passenger and  
158.8 the vehicle driver; and (ii) who is certified as a protected transport provider; and

158.9 (7) stretcher transport, which includes transport for a client in a prone or supine position  
158.10 and requires a nonemergency medical transportation provider with a vehicle that can transport  
158.11 a client in a prone or supine position.

158.12 ~~(p)~~ (p) The local agency shall be the single administrative agency and shall administer  
158.13 and reimburse for modes defined in paragraph ~~(n)~~ (o) according to paragraphs ~~(r)~~ (s) to ~~(t)~~  
158.14 (u) when the commissioner has developed, made available, and funded the web-based single  
158.15 administrative structure, assessment tool, and level of need assessment under subdivision  
158.16 18e. The local agency's financial obligation is limited to funds provided by the state or  
158.17 federal government. This paragraph expires July 1, 2026, for medical assistance  
158.18 fee-for-service and January 1, 2027, for prepaid medical assistance.

158.19 ~~(p)~~ (q) The commissioner shall:

158.20 (1) verify that the mode and use of nonemergency medical transportation is appropriate;

158.21 (2) verify that the client is going to an approved medical appointment; and

158.22 (3) investigate all complaints and appeals.

158.23 ~~(q)~~ (r) The administrative agency shall pay for the services provided in this subdivision  
158.24 and seek reimbursement from the commissioner, if appropriate. As vendors of medical care,  
158.25 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary  
158.26 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.  
158.27 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,  
158.28 2027, for prepaid medical assistance.

158.29 ~~(r)~~ (s) Payments for nonemergency medical transportation must be paid based on the  
158.30 client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle used to provide the  
158.31 service. The medical assistance reimbursement rates for nonemergency medical transportation  
158.32 services that are payable by or on behalf of the commissioner for nonemergency medical  
158.33 transportation services are:

- 159.1 (1) \$0.22 per mile for client reimbursement;
- 159.2 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer  
159.3 transport;
- 159.4 (3) equivalent to the standard fare for unassisted transport when provided by public  
159.5 transit, and \$12.10 for the base rate and \$1.43 per mile when provided by a nonemergency  
159.6 medical transportation provider;
- 159.7 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;
- 159.8 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;
- 159.9 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and
- 159.10 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for  
159.11 an additional attendant if deemed medically necessary. This paragraph expires July 1, 2026,  
159.12 for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.
- 159.13 ~~(s)~~ (t) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,  
159.14 for prepaid medical assistance, payments for nonemergency medical transportation must  
159.15 be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle  
159.16 used to provide the service.
- 159.17 ~~(t)~~ (u) The base rate for nonemergency medical transportation services in areas defined  
159.18 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in  
159.19 paragraph ~~(r)~~ (s), clauses (1) to (7). The mileage rate for nonemergency medical transportation  
159.20 services in areas defined under RUCA to be rural or super rural areas is:
- 159.21 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage  
159.22 rate in paragraph ~~(r)~~ (s), clauses (1) to (7); and
- 159.23 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage  
159.24 rate in paragraph ~~(r)~~ (s), clauses (1) to (7). This paragraph expires July 1, 2026, for medical  
159.25 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.
- 159.26 ~~(u)~~ (v) For purposes of reimbursement rates for nonemergency medical transportation  
159.27 services under paragraphs ~~(r)~~ (s) to ~~(t)~~ (u), the zip code of the recipient's place of residence  
159.28 shall determine whether the urban, rural, or super rural reimbursement rate applies. This  
159.29 paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027,  
159.30 for prepaid medical assistance.

160.1 ~~(v)~~ (w) The commissioner, when determining reimbursement rates for nonemergency  
160.2 medical transportation, shall exempt all modes of transportation listed under paragraph ~~(n)~~  
160.3 (o) from Minnesota Rules, part 9505.0445, item R, subitem (2).

160.4 ~~(w)~~ (x) Effective for the first day of each calendar quarter in which the price of gasoline  
160.5 as posted publicly by the United States Energy Information Administration exceeds \$3.00  
160.6 per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(r)~~ (s) by one  
160.7 percent up or down for every increase or decrease of ten cents for the price of gasoline. The  
160.8 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage  
160.9 increase or decrease must be calculated using the average of the most recently available  
160.10 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy  
160.11 Information Administration. This paragraph expires July 1, 2026, for medical assistance  
160.12 fee-for-service and January 1, 2027, for prepaid medical assistance.

160.13 Sec. 10. Minnesota Statutes 2024, section 256B.0625, subdivision 17b, is amended to  
160.14 read:

160.15 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency  
160.16 medical transportation providers must document each occurrence of a service provided to  
160.17 a recipient according to this subdivision. Providers must maintain records sufficient to  
160.18 distinguish individual trips with specific vehicles and drivers. The documentation may be  
160.19 collected and maintained using electronic systems or software or in paper form but must be  
160.20 made available and produced upon request. Program funds paid for transportation that is  
160.21 not documented according to this subdivision may be subject to recovery by the commissioner  
160.22 pursuant to section 256B.064.

160.23 (b) A nonemergency medical transportation provider must compile transportation trip  
160.24 records that are written in English and legible according to the standard of a reasonable  
160.25 person and that include each of the following elements:

160.26 (1) the recipient's name;

160.27 (2) the date or dates the service is provided, if different than the date the entry was made;

160.28 (3) either the printed name of the driver sufficient to distinguish the driver of service or  
160.29 the driver's provider number;

160.30 (4) the date and the signature of the driver attesting that the record accurately represents  
160.31 the services provided and the actual miles driven, and acknowledging that misreporting  
160.32 information that results in ineligible or excessive payments may result in civil or criminal  
160.33 action;

161.1 (5) the date and the signature of the recipient or authorized party attesting that  
161.2 transportation services were provided as indicated on the transportation trip record, or the  
161.3 signature of the medical services provider certifying that the recipient was transported to  
161.4 the medical services provider destination. In the event that both the medical services provider  
161.5 and the recipient or authorized party refuse or are unable to provide signatures, the driver  
161.6 must document on the transportation trip record that signatures were requested and not  
161.7 provided;

161.8 (6) the address, or the description if the address is not available, of both the origin and  
161.9 destination, and the mileage for the most direct route from the origin to the destination;

161.10 (7) the name or number of the mode of transportation in which the service is provided;

161.11 (8) the license plate number of the vehicle used to transport the recipient;

161.12 (9) the time of the recipient pickup;

161.13 (10) the time of the recipient drop-off;

161.14 (11) the odometer reading of the vehicle used to transport the recipient taken at the time  
161.15 of pickup;

161.16 (12) the odometer reading of the vehicle used to transport the recipient taken at the time  
161.17 of drop-off;

161.18 (13) the name of the extra attendant when an extra attendant is used to provide special  
161.19 transportation service; and

161.20 (14) the documentation indicating the method that was used to determine the most direct  
161.21 route.

161.22 (c) In determining whether the commissioner will seek recovery, the documentation  
161.23 requirements in this section apply retroactively to audit findings beginning January 1, 2020,  
161.24 and to all audit findings thereafter.

161.25 (d) Effective January 1, 2027, or upon federal approval, whichever is later, records that  
161.26 comply with section 256B.073 may be used to meet the requirements of this subdivision if  
161.27 all required elements are included in the record.

162.1 Sec. 11. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision  
162.2 to read:

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

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

162.7 Sec. 12. Minnesota Statutes 2024, section 256B.073, subdivision 1, is amended to read:

162.8 Subdivision 1. **Documentation; establishment and operation.** The commissioner of  
162.9 human services shall establish ~~implementation requirements and standards for~~ and maintain  
162.10 the requirements and standards for the ongoing operation of electronic visit verification to  
162.11 comply with the 21st Century Cures Act, Public Law 114-255. Within available  
162.12 appropriations, the commissioner shall take steps to comply with the electronic visit  
162.13 verification requirements in the 21st Century Cures Act, Public Law 114-255.

162.14 Sec. 13. Minnesota Statutes 2024, section 256B.073, subdivision 2, is amended to read:

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

162.17 (b) "Data aggregator" means the entity designated by the commissioner to collect, store,  
162.18 and transmit electronic visit verification data from providers and third-party systems to the  
162.19 commissioner in accordance with the standards and requirements established under this  
162.20 section.

162.21 ~~(b)~~ (c) "Electronic visit verification" or "EVV" means the electronic documentation of  
162.22 the process required under United States Code, title 42, section 1396b(1), and this section  
162.23 used to electronically verify the:

162.24 (1) type of service performed;

162.25 (2) individual receiving the service;

162.26 (3) date of the service;

162.27 (4) location of the service delivery;

162.28 (5) individual providing the service; ~~and~~

162.29 (6) time the service begins and ends; and

163.1 (7) method by which the service recipient, the service recipient's legal guardian or  
163.2 conservator, or the service recipient's parent, if the service recipient is a minor, attests to  
163.3 the accuracy of the information contained on the electronic visit verification.

163.4 (d) "Electronic visit verification data" means information collected through an electronic  
163.5 visit verification system, including data elements required under United States Code, title  
163.6 42, section 1396b(l), and any additional data elements specified by the commissioner under  
163.7 this section.

163.8 ~~(e)~~ (e) "Electronic visit verification system" means a system that provides electronic  
163.9 verification of services used to collect, verify, and transmit electronic visit verification data  
163.10 to the commissioner or the commissioner's designated data aggregator that complies with  
163.11 the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

163.12 (f) "Electronic visit verification vendor" means any entity that develops, provides, or  
163.13 supports an electronic visit verification system, including the state-provided vendor and  
163.14 any third-party vendor.

163.15 (g) "Financial management services provider" means an entity enrolled with the  
163.16 commissioner to provide financial management services under section 256B.85 or other  
163.17 applicable law and responsible for fiscal, payroll, and reporting functions on behalf of  
163.18 participant employers.

163.19 (h) "Home health agency" means a home care provider agency that is Medicare certified  
163.20 under Code of Federal Regulations, title 42, part 484, and licensed as a home care provider  
163.21 under chapter 144A.

163.22 (i) "Individual" means a person who receives services subject to electronic visit  
163.23 verification under the medical assistance program.

163.24 (j) "Managed care organization" means a public or private organization that contracts  
163.25 with the commissioner under section 256B.69 or other applicable law to deliver health care  
163.26 services to individuals eligible for medical assistance or MinnesotaCare.

163.27 (k) "Manual visit" means a visit:

163.28 (1) entered administratively and not by the caregiver at the time of service delivery; or

163.29 (2) where data elements are edited after the time of service delivery.

163.30 (l) "Provider" means an individual or organization that meets one or more of the following  
163.31 conditions:

163.32 (1) is enrolled as a Minnesota health care programs provider;

164.1 (2) provides services through a managed care organization under contract with the  
164.2 commissioner under section 256B.69;

164.3 (3) is a financial management services provider; or

164.4 (4) is a participant employer under section 256B.85, subdivision 7, or an employer of  
164.5 record directing services under section 256B.49, subdivision 16.

164.6 ~~(d)~~ (m) "Service" means one of the following:

164.7 (1) personal care assistance services as defined in section 256B.0625, subdivision 19a,  
164.8 and provided according to section 256B.0659;

164.9 (2) community first services and supports under section 256B.85;

164.10 (3) home health services under section 256B.0625, subdivision 6a; ~~or~~

164.11 (4) adult companion services;

164.12 (5) adult day services;

164.13 (6) adult rehabilitative mental health services;

164.14 (7) assertive community treatment;

164.15 (8) early intensive developmental and behavioral intervention;

164.16 (9) integrated community supports;

164.17 (10) nonemergency medical transportation services;

164.18 (11) recovery peer support;

164.19 (12) recuperative care;

164.20 (13) home and community-based services reimbursed at an hourly or specified

164.21 minute-based rate and provided according to a federally approved waiver plan as authorized  
164.22 under chapter 256S or section 256B.0913, 256B.092, or 256B.49; or

164.23 (14) other medical supplies and equipment or home and community-based services that  
164.24 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

164.25 (n) "State-provided electronic visit verification system" means the electronic visit  
164.26 verification system made available by the commissioner to providers at no cost for services  
164.27 subject to federal electronic visit verification requirements.

164.28 (o) "Third-party electronic visit verification system" means an electronic visit verification  
164.29 system purchased or operated by a provider or vendor other than the state-provided system  
164.30 designated by the commissioner.

165.1 (p) "Verification method" means the electronic process used to capture and verify visit  
165.2 information, including telephone, fixed visit verification devices, or mobile applications,  
165.3 as approved by the commissioner.

165.4 (q) "Visit" means a single occurrence of service delivery subject to electronic visit  
165.5 verification.

165.6 (r) "Worker" means an individual who provides personal care assistance services,  
165.7 community first services and supports, home health services, consumer-directed community  
165.8 supports, or other services identified by the commissioner as subject to electronic visit.

165.9 Sec. 14. Minnesota Statutes 2024, section 256B.073, subdivision 3, is amended to read:

165.10 Subd. 3. **Requirements.** (a) ~~In developing implementation requirements for administering~~  
165.11 ~~electronic visit verification, the commissioner shall~~ must ensure that the system and related  
165.12 requirements:

165.13 (1) ~~are minimally administratively and financially burdensome to a provider~~ reasonable  
165.14 for providers of services;

165.15 (2) ~~are minimally burdensome~~ support continued access to the services and are designed  
165.16 to avoid disruption to service recipient and the least disruptive to the service recipient in  
165.17 ~~receiving and maintaining allowed services~~ delivery or receipt;

165.18 (3) consider existing best practices and use of electronic visit verification;

165.19 (4) are conducted according to all state and federal laws;

165.20 (5) are effective methods for preventing fraud when balanced against the requirements  
165.21 of clauses (1) and (2); and

165.22 (6) are consistent with the Department of Human Services' policies related to covered  
165.23 services, flexibility of service use, and quality assurance.

165.24 (b) The commissioner ~~shall~~ must make training and guidance available to providers of  
165.25 services on the electronic visit verification system requirements and system use.

165.26 (c) The commissioner ~~shall~~ must establish baseline measurements related to preventing  
165.27 fraud and establish measures to determine the effect of electronic visit verification  
165.28 requirements on program integrity.

165.29 (d) The commissioner ~~shall~~ must make a state-selected state-provided electronic visit  
165.30 verification system available to providers of services.

166.1 (e) The commissioner ~~shall~~ must make available and publish on the agency website the  
166.2 name and contact information for the vendor of the ~~state-selected~~ state-provided electronic  
166.3 visit verification system and the other vendors that offer alternative electronic visit  
166.4 verification systems. The information provided must state that the ~~state-selected~~  
166.5 state-provided electronic visit verification system is offered at no cost to the provider of  
166.6 services and that the provider of services may choose an alternative system that may be at  
166.7 a cost to the provider.

166.8 (f) The commissioner may establish implementation dates and implementation schedules  
166.9 for system functions subject to electronic visit verification under this section, including but  
166.10 not limited to verification methods or technical requirements.

166.11 (g) The commissioner may waive the requirements of this section for any service  
166.12 component or setting when the application of electronic visit verification is contrary to  
166.13 paragraph (a).

166.14 Sec. 15. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision  
166.15 to read:

166.16 Subd. 4a. **Electronic visit verification system options.** (a) A provider of services must  
166.17 use an electronic visit verification system that complies with the requirements established  
166.18 by the commissioner. A provider of services may use either the state-provided system or a  
166.19 third-party system. All systems used for compliance must provide data to the commissioner  
166.20 in the format and frequency required by the commissioner.

166.21 (b) The commissioner must make a state-provided electronic visit verification system  
166.22 available at no cost to providers of services. The commissioner must provide training on  
166.23 the system to all providers of services.

166.24 (c) The commissioner must allow providers of services to utilize a third-party electronic  
166.25 visit verification system that the commissioner determines meets the requirements of this  
166.26 section.

166.27 (d) A provider of services using a third-party electronic visit verification system that  
166.28 meets all technical specifications and federal and state laws must:

166.29 (1) collect and submit all data for each visit to the commissioner, including but not  
166.30 limited to manual entries;

166.31 (2) maintain compliance identified by the commissioner, including but not limited to  
166.32 incorporating into the system any changes in data requirements that must be transmitted to  
166.33 the commissioner; and

167.1 (3) integrate the system with the data aggregator to accurately send data.

167.2 (e) The data aggregator must be available at no cost to a provider of services for purposes  
167.3 of transmitting electronic visit verification data from approved third-party systems to the  
167.4 commissioner. Any costs associated with the development and use of a third-party system  
167.5 are the responsibility of the provider.

167.6 (f) If a provider is unable to integrate a third-party system with the data aggregator, the  
167.7 provider of services must use the state-provided electronic visit verification system.

167.8 (g) The commissioner must provide training on reviewing and correcting imported data  
167.9 in the data aggregator to providers of services.

167.10 Sec. 16. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision  
167.11 to read:

167.12 Subd. 4b. **Provider responsibilities.** A provider of services must:

167.13 (1) use an electronic visit verification system that meets all technical and data submission  
167.14 requirements established by the commissioner;

167.15 (2) enroll with the state-provided electronic visit verification system or the data  
167.16 aggregator, as applicable;

167.17 (3) provide all information requested by the commissioner for enrollment, access, and  
167.18 data submission and ensure that such information remains accurate and up to date;

167.19 (4) maintain records for each individual receiving services subject to electronic visit  
167.20 verification, including but not limited to all required data elements;

167.21 (5) maintain a current list of workers providing services subject to electronic visit  
167.22 verification to individuals receiving services under medical assistance;

167.23 (6) provide the commissioner and any managed care organization with immediate, direct,  
167.24 and on-site or remote access to the electronic visit verification system;

167.25 (7) at the request of the commissioner or a managed care organization, allow review or  
167.26 copying of electronic visit verification documentation at no cost;

167.27 (8) ensure that electronic visit verification systems and related processes meet accessibility  
167.28 and confidentiality requirements under state and federal law;

167.29 (9) comply with all policies, procedures, and technical specifications issued by the  
167.30 commissioner under this section; and

168.1 (10) ensure that workers, participants, and other individuals using electronic visit  
168.2 verification are trained and comply with all documentation and data entry requirements  
168.3 established by the commissioner.

168.4 Sec. 17. Minnesota Statutes 2024, section 256B.073, subdivision 5, is amended to read:

168.5 Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system  
168.6 ~~selected~~ provided by the commissioner and the vendor's affiliate must comply with the  
168.7 requirements of this subdivision.

168.8 (b) The vendor of the ~~state-selected~~ state-provided electronic visit verification system  
168.9 and the vendor's affiliate must:

168.10 (1) notify the provider of services that the provider may choose the ~~state-selected~~  
168.11 state-provided electronic visit verification system at no cost to the provider;

168.12 (2) offer the ~~state-selected~~ state-provided electronic visit verification system to the  
168.13 provider of services prior to offering any fee-based electronic visit verification system;

168.14 (3) notify the provider of services that the provider may choose any fee-based electronic  
168.15 visit verification system prior to offering the vendor's or its affiliate's fee-based electronic  
168.16 visit verification system; and

168.17 (4) when offering the ~~state-selected~~ state-provided electronic visit verification system,  
168.18 clearly differentiate between the ~~state-selected~~ state-provided electronic visit verification  
168.19 system and the vendor's or its affiliate's alternative fee-based system.

168.20 (c) The vendor of the ~~state-selected~~ state-provided electronic visit verification system  
168.21 and the vendor's affiliate must not use state data that are not available to other vendors of  
168.22 electronic visit verification systems to promote or sell the vendor's or its affiliate's alternative  
168.23 electronic visit verification system.

168.24 (d) Upon request from the provider, the vendor of the ~~state-selected~~ state-provided  
168.25 electronic visit verification system must provide proof of compliance with the requirements  
168.26 of paragraph (b).

168.27 (e) An agreement between the vendor of the ~~state-selected~~ state-provided electronic visit  
168.28 verification system or its affiliate and a provider of services for an electronic visit verification  
168.29 system that is not the ~~state-selected~~ state-provided system entered into on or after July 1,  
168.30 2023, is subject to immediate termination by the provider if the vendor violates any of the  
168.31 requirements of paragraph (b).

169.1 Sec. 18. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision  
169.2 to read:

169.3 Subd. 6. **Data and documentation.** (a) A provider of services must submit electronic  
169.4 visit verification data to the commissioner or the data aggregator in accordance with the  
169.5 technical standards, format, and frequency established under this section. The commissioner  
169.6 may use integrated electronic visit verification data for oversight, quality assurance, and  
169.7 program integrity purposes consistent with state and federal law.

169.8 (b) The commissioner and managed care organizations must use electronic visit  
169.9 verification data to validate claims for payment under medical assistance. Claims that cannot  
169.10 be validated in accordance with electronic visit verification requirements may be subject  
169.11 to actions by the commissioner as authorized under state and federal law, including actions  
169.12 related to payment, program integrity, or provider compliance.

169.13 (c) A provider of services must record all required electronic visit verification data at  
169.14 the time of service delivery using an approved verification method. To be compliant with  
169.15 electronic visit verification requirements, a provider of services must document a visit with  
169.16 all required data elements recorded at the time of service delivery.

169.17 (d) A manual visit does not comply with electronic visit verification requirements. A  
169.18 manual visit must be confirmed and verified according to processes established by the  
169.19 commissioner before being used to validate or support a claim for payment.

169.20 (e) A worker providing services subject to electronic visit verification must record the  
169.21 start and end times of each visit at the time the service is delivered using an approved  
169.22 verification method. A worker must complete and verify all time documentation, including  
169.23 but not limited to verification of service type, date, and duration, on the date the service  
169.24 occurs and be consistent with documentation requirements of the service being provided.  
169.25 A provider of services must maintain documentation demonstrating compliance with this  
169.26 subdivision and make the documentation available to the commissioner or a managed care  
169.27 organization upon request.

169.28 Sec. 19. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision  
169.29 to read:

169.30 Subd. 7. **Third-party system responsibilities.** (a) This subdivision is effective for Early  
169.31 Intensive Developmental and Behavioral Intervention services beginning July 1, 2027, or  
169.32 upon federal approval, whichever is later. This subdivision is effective for all other services

170.1 subject to this subdivision beginning January 1, 2027, or upon federal approval, whichever  
170.2 is later.

170.3 (b) A provider of services using a third-party electronic visit verification system must  
170.4 ensure that the system meets all technical, functional, and data-exchange requirements  
170.5 established by the commissioner and transmits data to the commissioner or the data  
170.6 aggregator in the format and frequency required by the commissioner.

170.7 (c) A third-party electronic visit verification vendor must:

170.8 (1) comply with all technical, contractual, privacy, and security standards established  
170.9 by the commissioner;

170.10 (2) not use or disclose state data for any purpose other than fulfilling the requirements  
170.11 of this section or federal law;

170.12 (3) provide the commissioner access to system documentation, data mapping, and audit  
170.13 records upon request; and

170.14 (4) immediately report to the commissioner any data transmission failure, breach, or  
170.15 interruption affecting the commissioner's ability to receive required electronic visit  
170.16 verification data.

170.17 (d) A provider of services remains responsible for ensuring compliance with this section  
170.18 even when using a third-party electronic visit verification system.

170.19 (e) The third-party vendor must ensure training on the system is available to providers  
170.20 of services.

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

170.22 Sec. 20. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

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

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

170.26 (2) provide the services in this section; ~~and~~

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

170.30 (4) grant limited role-based access to a person's support plan in the MnCHOICES system  
170.31 to home and community-based service providers who have been designated as a provider

171.1 for that person by a lead agency for the purpose of signing the person's support plan  
171.2 electronically and demonstrating that the provider has reviewed, understood, and agrees to  
171.3 deliver services as outlined in the plan.

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

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

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

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

171.15 Sec. 21. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 2, is  
171.16 amended to read:

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

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

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

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

171.31 (1) is severe and chronic;

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

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

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

172.9 (i) behavioral challenges and self-regulation;

172.10 (ii) cognition;

172.11 (iii) learning and play;

172.12 (iv) self-care; or

172.13 (v) safety.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

174.3 Sec. 22. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is  
174.4 amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

175.19 (16) provide the required EIDBI intervention observation and direction by a QSP or  
175.20 Level I provider at least once per month. Notwithstanding subdivision 13, paragraph (1),  
175.21 required EIDBI intervention observation and direction under this clause may be conducted  
175.22 via telehealth provided that no more than two consecutive monthly required EIDBI  
175.23 intervention observation and direction sessions under this clause are conducted via telehealth.

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

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

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

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

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

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

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

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

176.9 Sec. 23. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision  
176.10 to read:

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

176.15 (b) All documentation must:

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

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

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

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

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

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

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

176.27 (8) be available for review or audit;

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

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

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

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

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

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

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

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

177.10 (5) a background check pursuant to chapter 245C;

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

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

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

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

177.18 (10) the employee's annual performance evaluations.

177.19 Sec. 24. Minnesota Statutes 2024, section 256B.4912, subdivision 12, is amended to read:

177.20 Subd. 12. **Home and community-based service documentation requirements.** (a)

177.21 Unless the provider is required to use an electronic visit verification system authorized  
177.22 under section 256B.073, the provider must collect and maintain documentation ~~may be~~  
177.23 ~~collected and maintained~~ electronically or in paper form ~~by providers and must be produced.~~

177.24 The provider must produce all documentation upon request by the commissioner.

177.25 (b) Documentation of a delivered service must be in English and must be legible according  
177.26 to the standard of a reasonable person.

177.27 (c) If the service is reimbursed at an hourly or specified minute-based rate, each  
177.28 documentation of the provision of a service, unless otherwise specified, must include:

177.29 (1) the date the documentation occurred;

177.30 (2) the day, month, and year when the service was provided;

178.1 (3) the start and stop times with a.m. and p.m. designations, except for case management  
178.2 services as defined under chapter 256S and sections 256B.0913, subdivision 7; 256B.092,  
178.3 subdivision 1a; and 256B.49, subdivision 13;

178.4 (4) the service name or description of the service provided; and

178.5 (5) the name, signature, and title, if any, of the provider of service. If the service is  
178.6 provided by multiple staff members, the provider may designate a staff member responsible  
178.7 for verifying services and completing the documentation required by this paragraph.

178.8 (d) If the service is reimbursed at a daily rate or does not meet the requirements in  
178.9 paragraph (c), each documentation of the provision of a service, unless otherwise specified,  
178.10 must include:

178.11 (1) the date the documentation occurred;

178.12 (2) the day, month, and year when the service was provided;

178.13 (3) the service name or description of the service provided; and

178.14 (4) the name, signature, and title, if any, of the person providing the service. If the service  
178.15 is provided by multiple staff, the provider may designate a staff member responsible for  
178.16 verifying services and completing the documentation required by this paragraph. The  
178.17 designated staff member verifying the services must include in the documentation of the  
178.18 provision of a service the names of all staff who provided the service.

178.19 Sec. 25. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision  
178.20 to read:

178.21 Subd. 17. **Prohibition on room and board payments.** (a) The provider must not use  
178.22 medical assistance money to pay for room and board, including but not limited to rent,  
178.23 mortgage payments, utilities, property taxes, homeowners association fees, or any other  
178.24 housing-related cost, in accordance with federal home and community-based services waiver  
178.25 requirements under United States Code, title 42, section 1396n(c), and Code of Federal  
178.26 Regulations, title 42, section 441.310.

178.27 (b) A provider of home and community-based services, including but not limited to  
178.28 integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause  
178.29 (8), must not:

178.30 (1) use, allocate, or apply any payment for home and community-based services to cover,  
178.31 subsidize, discount, or otherwise contribute to any room and board expenses for a person  
178.32 receiving services;

179.1 (2) apply agency operating margins, reserves, or profits derived from home and  
179.2 community-based services to pay for rent or pay other housing costs for persons receiving  
179.3 services; or

179.4 (3) enter into any financial arrangement, discount, concession, or reimbursement structure  
179.5 that has the effect of using medical assistance service revenue to offset the housing costs  
179.6 of a person receiving services.

179.7 (c) Nothing in this subdivision prohibits a provider from charging a person for room  
179.8 and board in accordance with chapter 504B or applicable housing support laws, provided  
179.9 the charge is independent of medical assistance payments and complies with all federal  
179.10 home and community-based services setting requirements, including but not limited to  
179.11 tenancy protections under Code of Federal Regulations, title 42, section 441.301(c)(4)(vi)(A).

179.12 (d) The commissioner may pursue corrective action, payment recovery, sanctions under  
179.13 section 256B.064, and licensing action under chapter 245A or 245D for a violation of this  
179.14 subdivision.

179.15 (e) Notwithstanding paragraphs (a) and (b), payment for room and board is permitted  
179.16 when explicitly included as part of a service authorized in a federally approved home and  
179.17 community-based services waiver under United States Code, title 42, section 1396n(c).

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

179.19 Sec. 26. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 5a, is  
179.20 amended to read:

179.21 Subd. 5a. **Base wage index; calculations.** The base wage index must be calculated as  
179.22 follows:

179.23 (1) for supervisory staff, 100 percent of the median wage for community and social  
179.24 services specialist (SOC code 21-1099), with the exception of the supervisor of positive  
179.25 supports professional, positive supports analyst, and positive supports specialist, which is  
179.26 100 percent of the median wage for clinical counseling and school psychologist (SOC code  
179.27 19-3031);

179.28 (2) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC  
179.29 code 29-1141);

179.30 (3) for licensed practical nurse staff, 100 percent of the median wage for licensed practical  
179.31 nurses (SOC code 29-2061);

180.1 (4) for residential asleep-overnight staff, the minimum wage in Minnesota for large  
180.2 employers;

180.3 (5) for residential direct care staff, the sum of:

180.4 (i) 15 percent of the subtotal of 50 percent of the median wage for home health and  
180.5 personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant  
180.6 (SOC code 31-1131); and 20 percent of the median wage for social and human services  
180.7 aide (SOC code 21-1093); and

180.8 (ii) 85 percent of the subtotal of 40 percent of the median wage for home health and  
180.9 personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant  
180.10 (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code  
180.11 29-2053); and 20 percent of the median wage for social and human services aide (SOC code  
180.12 21-1093);

180.13 (6) for adult day services staff, 70 percent of the median wage for nursing assistant (SOC  
180.14 code 31-1131); and 30 percent of the median wage for home health and personal care aide  
180.15 (SOC code 31-1120);

180.16 (7) for day support services staff and prevocational services staff, 20 percent of the  
180.17 median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for  
180.18 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social  
180.19 and human services aide (SOC code 21-1093);

180.20 (8) for positive supports analyst staff, 100 percent of the median wage for substance  
180.21 abuse, behavioral disorder, and mental health counselor (SOC code 21-1018);

180.22 (9) for positive supports professional staff, 100 percent of the median wage for clinical  
180.23 counseling and school psychologist (SOC code 19-3031);

180.24 (10) for positive supports specialist staff, 100 percent of the median wage for psychiatric  
180.25 technicians (SOC code 29-2053);

180.26 (11) for individualized home supports with family training staff, 20 percent of the median  
180.27 wage for nursing aide (SOC code 31-1131); 30 percent of the median wage for community  
180.28 social service specialist (SOC code 21-1099); 40 percent of the median wage for social and  
180.29 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric  
180.30 technician (SOC code 29-2053);

180.31 (12) for individualized home supports with training services staff, 40 percent of the  
180.32 median wage for community social service specialist (SOC code 21-1099); 50 percent of

181.1 the median wage for social and human services aide (SOC code 21-1093); and ten percent  
181.2 of the median wage for psychiatric technician (SOC code 29-2053);

181.3 (13) for employment support services staff, 50 percent of the median wage for  
181.4 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for  
181.5 community and social services specialist (SOC code 21-1099);

181.6 (14) for employment exploration services staff, 50 percent of the median wage for  
181.7 education, guidance, school, and vocational counselor (SOC code 21-1012); and 50 percent  
181.8 of the median wage for community and social services specialist (SOC code 21-1099);

181.9 (15) for employment development services staff, 50 percent of the median wage for  
181.10 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent  
181.11 of the median wage for community and social services specialist (SOC code 21-1099);

181.12 (16) for individualized home support without training staff, 50 percent of the median  
181.13 wage for home health and personal care aide (SOC code 31-1120); and 50 percent of the  
181.14 median wage for nursing assistant (SOC code 31-1131);

181.15 (17) effective until the effective date of clauses (18) and (19), for night supervision staff,  
181.16 40 percent of the median wage for home health and personal care aide (SOC code 31-1120);  
181.17 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the  
181.18 median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median  
181.19 wage for social and human services aide (SOC code 21-1093);

181.20 (18) effective January 1, 2026, or upon federal approval, whichever is later, for awake  
181.21 night supervision staff, 40 percent of the median wage for home health and personal care  
181.22 aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code  
181.23 31-1131); 20 of percent the median wage for psychiatric technician (SOC code 29-2053);  
181.24 and 20 percent of the median wage for social and human services aid (SOC code 21-1093);

181.25 ~~and~~

181.26 (19) effective January 1, 2026, or upon federal approval, whichever is later, for asleep  
181.27 night supervision staff, the minimum wage in Minnesota for large employers; and

181.28 (20) for integrated community support staff, 40 percent of the median wage for  
181.29 community and social services specialist (SOC code 21-1099); 50 percent of the median  
181.30 wage for social and human services aide (SOC code 21-1093); and ten percent of the median  
181.31 wage for psychiatric technician (SOC code 29-2053).

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

182.1 Sec. 27. Minnesota Statutes 2024, section 256B.4914, subdivision 6, is amended to read:

182.2 Subd. 6. **Residential support services; generally.** (a) For purposes of this section,  
182.3 residential support services includes 24-hour customized living services, community  
182.4 residential services, and customized living services, ~~and integrated community supports.~~

182.5 (b) A unit of service for residential support services is a day. Any portion of any calendar  
182.6 day, within allowable Medicaid rules, where an individual spends time in a residential setting  
182.7 is billable as a day. The number of days authorized for all individuals enrolling in residential  
182.8 support services must include every day that services start and end.

182.9 (c) When the available shared staffing hours in a residential setting are insufficient to  
182.10 meet the needs of an individual who enrolled in residential support services after January  
182.11 1, 2014, then individual staffing hours shall be used.

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

182.13 Sec. 28. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision  
182.14 to read:

182.15 Subd. 8a. **Integrated community supports unit-based services with programming;**  
182.16 **component values and calculation of payment rates.** (a) Component values for integrated  
182.17 community supports unit-based services with programming are:

182.18 (1) competitive workforce factor: 6.7 percent;

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

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

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

182.22 (5) program plan support ratio: 27 percent;

182.23 (6) client programming and support ratio: 9.2 percent;

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

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

182.26 (9) absence and utilization factor ratio: 9.4 percent.

182.27 (b) A unit of integrated community supports unit-based services with programming is  
182.28 15 minutes.

182.29 (c) Payments for integrated community supports must be calculated as follows:

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

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

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

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

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

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

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

183.14 (8) for program plan support, multiply the result of clause (7) by one plus the program  
183.15 plan support ratio divided by the approved capacity for the integrated community supports  
183.16 setting;

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

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

183.21 (11) this is the subtotal rate;

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

183.24 (13) divide the result of clause (11) by one minus the result of clause (12). This is the  
183.25 total payment amount.

183.26 (d) The commissioner must establish maximum allowable in-person and remote service  
183.27 hours used in the rate methodology for integrated community supports based on the recipient's  
183.28 case-mix classification. The total number of service hours entered into the rate framework  
183.29 must not exceed the following limits:

183.30 (1) for case mix classifications A, C, and L, a maximum of two hours per day;

183.31 (2) for case mix classifications B, D, and F, a maximum of four hours per day;

184.1 (3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

184.2 (4) for case mix classification H, a maximum of eight hours per day.

184.3 (e) The daily limit in paragraph (d) does not limit a person's use of other disability waiver  
184.4 services, which may be provided on the same day by the same provider providing integrated  
184.5 community supports. Nothing in paragraph (d) prohibits approval of a rate exception for  
184.6 individuals with exceptional or complex needs.

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

184.8 Sec. 29. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision  
184.9 to read:

184.10 **Subd. 10e. Documentation of staffing; auditing and rate review.** (a) Effective for  
184.11 services provided on or after January 1, 2029, a provider enrolled to provide residential  
184.12 services under subdivision 6 must maintain documentation of direct staffing hours provided  
184.13 to each person receiving services, including but not limited to documentation identifying:

184.14 (1) the name, role, and unique identifier for each staff person who provided services to  
184.15 match records to payroll, time and attendance systems, and any other source documentation;

184.16 (2) the date services were provided;

184.17 (3) the total number of hours of direct support provided;

184.18 (4) awake overnight staffing hours provided, if applicable;

184.19 (5) asleep overnight staffing hours provided, if applicable; and

184.20 (6) any other staffing information required by the commissioner.

184.21 (b) A provider must maintain documentation in a manner and format determined by the  
184.22 commissioner for at least six years. If a provider changes payroll vendors, merges operations,  
184.23 or changes staffing identifiers, the provider must maintain a documented link between prior  
184.24 and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and  
184.25 role classification for each staff person.

184.26 (c) A provider must submit the documentation required under paragraph (a) to the  
184.27 commissioner annually, in a manner and format determined by the commissioner. The  
184.28 commissioner must establish multiple submission windows throughout the calendar year  
184.29 and may assign providers to a submission window for administrative efficiency and system  
184.30 capacity. Documentation must reflect staffing provided during the prior calendar year and  
184.31 must be submitted no later than the final business day of the provider's assigned submission

185.1 window. The commissioner may conduct random or targeted validations and audits of  
185.2 submitted data and may require supplemental documentation as necessary to verify accuracy  
185.3 and compliance.

185.4 (d) The commissioner must conduct periodic analysis of documentation submitted under  
185.5 this subdivision and may validate staffing data through random audits or other verification  
185.6 methods.

185.7 (e) Based on the analysis under paragraph (d), the commissioner may provide  
185.8 recommendations to lead agencies regarding modifications to the rate of a person receiving  
185.9 services, including increases or decreases necessary to align the rate with staffing provided  
185.10 to the person as demonstrated by the submitted historical staffing documentation.  
185.11 Recommendations must be based on the requirements of this section and applicable federal  
185.12 and state requirements governing rate setting.

185.13 (f) If a provider fails to submit documentation requested within the submission window  
185.14 in paragraph (c), the commissioner must issue a written notice of noncompliance. If  
185.15 documentation is not received within 60 days following the notice of noncompliance, the  
185.16 commissioner may temporarily suspend payments to the provider until the required  
185.17 documentation is submitted. The commissioner must make withheld payments to the provider  
185.18 once the required documentation is received. If such noncompliance persists, the  
185.19 commissioner may adjust future rate payments, require the provider to submit a corrective  
185.20 action plan, or pursue other enforcement actions as authorized by law.

185.21 (g) The commissioner must publish annual aggregate reports summarizing audit findings  
185.22 and trends related to staffing provided under this section.

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

185.24 Sec. 30. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision  
185.25 to read:

185.26 Subd. 21. **Administrative fees charged by providers and vendors.** Effective July 1,  
185.27 2027, or upon federal approval, whichever is later, the commissioner must limit  
185.28 administrative fees charged by enrolled providers and vendors approved by lead agencies  
185.29 to no more than six percent of the total cost of the service or purchased goods. This limit  
185.30 applies to the following services and other new market rate services as determined by the  
185.31 commissioner:

185.32 (1) chore services billed daily;

185.33 (2) transitional services; and

186.1 (3) transportation.

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

186.3 Sec. 31. Minnesota Statutes 2024, section 256B.492, is amended by adding a subdivision  
186.4 to read:

186.5 Subd. 4. **Integrated community supports setting approval moratorium and**  
186.6 **exception.** (a) The commissioner must not approve a new integrated community supports  
186.7 setting or approve an expansion of an existing integrated community supports setting except  
186.8 as provided in this subdivision.

186.9 (b) The commissioner may approve an exception to the moratorium only when the  
186.10 applicant demonstrates indirect control of the setting and compliance with:

186.11 (1) the federal home and community-based services requirements under Code of Federal  
186.12 Regulations, title 42, section 441.301(c);

186.13 (2) the prohibition on the use of medical assistance money for room and board under  
186.14 section 256B.4912, subdivision 17;

186.15 (3) independent lease requirements consistent with chapter 504B; and

186.16 (4) all documentation requirements under section 245D.12.

186.17 (c) To approve an exception, the commissioner must determine that the lead agency has  
186.18 requested the additional capacity to meet the specific disability-related needs of the person.  
186.19 Priority must be given to geographic regions with insufficient integrated community supports  
186.20 capacity based on statewide or regional needs determination processes.

186.21 (d) For purposes of this subdivision, "integrated community supports setting" means a  
186.22 multifamily housing building where a provider delivers integrated community supports  
186.23 under section 245D.03, subdivision 1, paragraph (c), clause (8), and for which a provider  
186.24 has a provider-controlled or provider-associated financial interest as defined under section  
186.25 245A.02, subdivision 10b.

186.26 (e) Nothing in this subdivision authorizes the commissioner to revoke approval of a  
186.27 previously approved setting following a change of ownership permissible under section  
186.28 245A.043.

186.29 (f) A determination under this subdivision is final and not subject to appeal.

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

187.1 Sec. 32. Minnesota Statutes 2024, section 256I.03, subdivision 10a, is amended to read:

187.2 Subd. 10a. **Housing support.** "Housing support" means assistance that provides at a  
187.3 minimum room and board to persons who meet the eligibility requirements of section  
187.4 256I.04. To receive payment for housing support, the residence must meet the requirements  
187.5 under:

187.6 (1) section 256I.04, subdivisions subdivision 2a, or 256I.041; and

187.7 (2) section 256I.04, subdivisions 2b to 2f.

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

187.9 Sec. 33. Minnesota Statutes 2024, section 256I.04, subdivision 1, is amended to read:

187.10 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and  
187.11 entitled to a housing support payment to be made on the individual's behalf if ~~the~~ an agency  
187.12 ~~has approved the setting~~ or the commissioner has a housing support agreement with the  
187.13 establishment where the individual will receive housing support and the individual meets  
187.14 the requirements in paragraph (a), (b), (c), or (d).

187.15 (a) The individual is aged, blind, or is over 18 years of age with a disability as determined  
187.16 under the criteria used by the title II program of the Social Security Act, and meets the  
187.17 resource restrictions and standards of section 256P.02, and the individual's countable income  
187.18 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical  
187.19 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the  
187.20 income actually made available to a community spouse by an elderly waiver participant  
187.21 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,  
187.22 subdivision 2, is less than the monthly rate specified in the agency's agreement with the  
187.23 provider of housing support in which the individual resides.

187.24 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,  
187.25 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the  
187.26 individual's resources are less than the standards specified by section 256P.02, and the  
187.27 individual's countable income as determined under section 256P.06, less the medical  
187.28 assistance personal needs allowance under section 256B.35 is less than the monthly rate  
187.29 specified in the agency's agreement with the provider of housing support in which the  
187.30 individual resides.

187.31 (c) The individual lacks a fixed, adequate, nighttime residence upon discharge from a  
187.32 residential behavioral health treatment program, as determined by treatment staff from the  
187.33 residential behavioral health treatment program. An individual is eligible under this paragraph

188.1 for up to three months, including a full or partial month from the individual's move-in date  
188.2 at a setting approved for housing support following discharge from treatment, plus two full  
188.3 months.

188.4 (d) The individual meets the criteria related to establishing a certified disability or  
188.5 disabling condition in paragraph (a) or (b) and lacks a fixed, adequate, nighttime residence  
188.6 upon discharge from a correctional facility, as determined by an authorized representative  
188.7 from a Minnesota-based correctional facility. An individual is eligible under this paragraph  
188.8 for up to three months, including a full or partial month from the individual's move-in date  
188.9 at a setting approved for housing support following release, plus two full months. Any  
188.10 income received by people who meet the disabling condition criteria established in paragraph  
188.11 (a) or (b) is not countable for the duration of eligibility under this paragraph.

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

188.13 Sec. 34. Minnesota Statutes 2025 Supplement, section 256I.04, subdivision 2a, is amended  
188.14 to read:

188.15 Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph  
188.16 (b), an agency may not enter into an agreement with an establishment to provide housing  
188.17 support unless:

188.18 (1) the establishment is licensed by the Department of Health as a hotel and restaurant;  
188.19 a board and lodging establishment; a boarding care home before March 1, 1985; or a  
188.20 supervised living facility, and the service provider for residents of the facility is licensed  
188.21 under chapter 245A. However, an establishment licensed by the Department of Health to  
188.22 provide lodging need not also be licensed to provide board if meals are being supplied to  
188.23 residents under a contract with a food vendor who is licensed by the Department of Health;  
188.24 or

188.25 (2) the residence is: (i) licensed by the commissioner of human services under Minnesota  
188.26 Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior  
188.27 to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265;  
188.28 (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120,  
188.29 with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02,  
188.30 subdivision 4a, as a community residential setting by the commissioner of human services;  
188.31 or

188.32 (3) the facility is licensed under chapter 144G and provides three meals a day; ~~or.~~

189.1 ~~(4) effective January 1, 2027, the establishment is licensed by the Department of Health~~  
189.2 ~~as a board and lodging establishment and is certified by the commissioner as a recovery~~  
189.3 ~~residence in accordance with section 254B.215, subdivision 3, that is subject to the~~  
189.4 ~~requirements of section 256I.04, subdivisions 2a to 2f. The Department of Human Services~~  
189.5 ~~must serve as the lead agency for agreements entered into under this clause.~~

189.6 (b) ~~The requirements under paragraph (a) do not apply to establishments~~ An agency  
189.7 may enter into an agreement to provide housing support with an establishment exempt from  
189.8 state licensure because ~~they are~~ it is:

189.9 (1) located on an Indian reservations reservation and subject to tribal health and safety  
189.10 requirements; or

189.11 (2) a supportive housing establishments establishment where an individual has an  
189.12 approved habitability inspection and an individual lease agreement.

189.13 (c) Supportive housing establishments that serve individuals who have experienced  
189.14 long-term homelessness and emergency shelters must participate in the homeless management  
189.15 information system and a coordinated assessment system as defined by the commissioner.

189.16 (d) ~~Effective July 1, 2016,~~ An agency shall not have an agreement with a provider of  
189.17 housing support unless all staff members who have direct contact with recipients:

189.18 (1) have skills and knowledge acquired through one or more of the following:

189.19 (i) a course of study in a health- or human services-related field leading to a bachelor  
189.20 of arts, bachelor of science, or associate's degree;

189.21 (ii) one year of experience with the target population served;

189.22 (iii) experience as a mental health certified peer specialist according to section 256B.0615;  
189.23 or

189.24 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to  
189.25 144A.483;

189.26 (2) hold a current driver's license appropriate to the vehicle driven if transporting  
189.27 recipients;

189.28 (3) complete training on vulnerable adults mandated reporting and child maltreatment  
189.29 mandated reporting, where applicable; and

189.30 (4) complete housing support orientation training offered by the commissioner.

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

190.1 Sec. 35. Minnesota Statutes 2024, section 256I.04, subdivision 2f, is amended to read:

190.2 Subd. 2f. **Required services.** (a) In ~~authorized~~ settings authorized under subdivision 2a  
190.3 or under section 256I.041, providers ~~shall~~ must ensure that participants have at a minimum:

190.4 (1) food preparation and service for three nutritional meals a day on site;

190.5 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

190.6 (3) housekeeping, including cleaning and lavatory supplies or service; and

190.7 (4) maintenance and operation of the building and grounds, including heat, water, garbage  
190.8 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair  
190.9 and maintain equipment and facilities.

190.10 (b) In addition, when providers serve participants described in subdivision 1, paragraph

190.11 (c), the providers are required to assist the participants in applying for continuing housing  
190.12 support payments before the end of the eligibility period.

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

190.14 Sec. 36. **[256I.041] STATE-EXECUTED HOUSING SUPPORT AGREEMENTS.**

190.15 **Subdivision 1. State-executed housing support agreements.** At the request of the  
190.16 establishment, the commissioner may enter into a housing support agreement with the  
190.17 following types of establishments:

190.18 (1) a residence with an approved integrated community supports setting capacity report  
190.19 submitted under section 245D.12; and

190.20 (2) an establishment licensed by the commissioner of health as a board and lodging  
190.21 establishment and designated by the commissioner of human services as a level-two certified  
190.22 recovery residence under section 254B.215, subdivision 3.

190.23 **Subd. 2. Requirements of state-executed housing support agreements.** All housing  
190.24 support agreements into which the commissioner enters under this section are subject to the  
190.25 same requirements and limitations as housing support agreements entered into by other  
190.26 agencies, including the requirements of section 256I.04, subdivisions 2a to 2f.

190.27 **Subd. 3. Prohibited agreements.** The commissioner must not enter into housing support  
190.28 agreements with any establishment not described in subdivision 1.

190.29 **Subd. 4. Administration of state-executed housing support agreements.** For each  
190.30 state-executed housing support agreement, the commissioner must designate an agency that

191.1 must administer the agreement, including determining eligibility for housing support and  
191.2 making payments in accordance with the terms of the agreement.

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

191.4 Sec. 37. Minnesota Statutes 2024, section 256I.05, subdivision 11, is amended to read:

191.5 Subd. 11. **Cost-neutral transfers from the housing support fund.** (a) The commissioner  
191.6 is authorized to make cost-neutral transfers from the housing support fund for beds under  
191.7 this section to other funding programs administered by the department after consultation  
191.8 with the agency in which the affected beds are located.

191.9 (b) The commissioner may also make cost-neutral transfers from the housing support  
191.10 fund to agencies for beds removed from the housing support census under a plan submitted  
191.11 by the agency and approved by the commissioner.

191.12 (c) The commissioner shall make a cost-neutral transfer of funding from the housing  
191.13 support fund to the agency for emergency shelter beds removed from the housing support  
191.14 census under a plan submitted by the agency and approved by the commissioner. Plans  
191.15 submitted under this paragraph must include anticipated and actual outcomes for persons  
191.16 experiencing homelessness in emergency shelters.

191.17 (d) Plans submitted under paragraph (b) or (c) must describe: (1) improved efficiencies  
191.18 in administration; (2) requirements for individual eligibility; and (3) plans for quality  
191.19 assurance monitoring and quality assurance outcomes. The commissioner shall review  
191.20 agency plans to monitor implementation and outcomes at least biennially, and more  
191.21 frequently if the commissioner deems necessary.

191.22 (e) Funding under paragraph (b), (c), or (d) may be used for the provision of room and  
191.23 board or supplemental services according to section 256I.03, subdivisions 14a and 14b.  
191.24 Providers must meet the requirements of both (1) either section 256I.04, subdivision 2a, or  
191.25 section 256I.041, and (2) section 256I.04, subdivisions ~~2a~~ 2b to 2f. Funding must be allocated  
191.26 annually, and the room and board portion of the allocation shall be adjusted according to  
191.27 the percentage change in the housing support room and board rate. The commissioner or  
191.28 agency may return beds to the housing support fund with 180 days' notice, including financial  
191.29 reconciliation.

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

192.1 Sec. 38. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision  
192.2 to read:

192.3 **Subd. 4. Documentation of staffing; auditing and rate review for residential support**  
192.4 **services.** (a) For purposes of this subdivision, residential support services include 24-hour  
192.5 customized living services, customized living services, family adult foster care, and corporate  
192.6 adult foster care.

192.7 (b) Effective January 1, 2029, a provider enrolled to provide residential support services  
192.8 under this subdivision must maintain documentation of direct staffing hours provided to  
192.9 each person receiving services, including but not limited to documentation identifying:

192.10 (1) the name, role, and unique identifier for each staff person who provided services to  
192.11 match records to payroll, time and attendance systems, and any other source documentation;

192.12 (2) the date services were provided;

192.13 (3) the total number of hours of direct support provided;

192.14 (4) awake overnight staffing hours provided, if applicable;

192.15 (5) asleep overnight staffing hours provided, if applicable; and

192.16 (6) any other staffing information required by the commissioner.

192.17 (c) A provider must maintain documentation in a manner and format determined by the  
192.18 commissioner for at least six years. If a provider changes payroll vendors, merges operations,  
192.19 or changes staffing identifiers, the provider must maintain a documented link between prior  
192.20 and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and  
192.21 role classification for each staff person.

192.22 (d) A provider must submit the documentation required under paragraph (b) to the  
192.23 commissioner annually, in a manner and format determined by the commissioner. The  
192.24 commissioner must establish multiple submission windows throughout the calendar year  
192.25 and may assign providers to a submission window for administrative efficiency and system  
192.26 capacity. Documentation must reflect staffing provided during the prior calendar year and  
192.27 must be submitted no later than the final business day of the provider's assigned submission  
192.28 window. The commissioner may conduct random or targeted validations and audits of  
192.29 submitted data and may require supplemental documentation as necessary to verify accuracy  
192.30 and compliance.

193.1 (e) The commissioner must conduct periodic analysis of documentation submitted under  
193.2 this subdivision and may validate staffing data through random audits or other verification  
193.3 methods.

193.4 (f) Based on the analysis under paragraph (e), the commissioner may provide  
193.5 recommendations to lead agencies regarding modifications to the rate of the person receiving  
193.6 services, including increases or decreases necessary to align the rate with staffing provided  
193.7 to the person as demonstrated by the submitted historical staffing documentation.  
193.8 Recommendations must be based on the requirements of this section and applicable federal  
193.9 and state requirements governing rate setting.

193.10 (g) If a provider fails to submit documentation requested within the submission window  
193.11 under paragraph (d), the commissioner must issue a written notice of noncompliance. If  
193.12 documentation is not received within 60 days following the notice of noncompliance, the  
193.13 commissioner may temporarily suspend payments to the provider until the required  
193.14 documentation is submitted. The commissioner must make withheld payments to the provider  
193.15 once the required documentation is received. If such noncompliance persists, the  
193.16 commissioner may adjust future rate payments, require the provider to submit a corrective  
193.17 action plan, or pursue other enforcement actions as authorized by law.

193.18 (h) The commissioner must publish annual aggregate reports summarizing audit findings  
193.19 and trends related to staffing provided under this section.

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

193.21 Sec. 39. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision  
193.22 to read:

193.23 Subd. 5. **Administrative fees charged by providers or vendors.** The commissioner  
193.24 must limit administrative fees charged by enrolled providers or vendors approved by lead  
193.25 agencies to no more than six percent of the total cost of the service or purchased goods.  
193.26 This limit applies to the following services but allows for the addition of other services  
193.27 determined by the commissioner:

193.28 (1) chore services billed daily;

193.29 (2) transitional services; and

193.30 (3) transportation.

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

194.1 Sec. 40. MARKET RATE STUDY FOR HOME AND COMMUNITY-BASED  
194.2 SERVICES.

194.3 (a) The commissioner of human services must conduct a market rate study to evaluate  
194.4 the adequacy, sustainability, and equity of payment rates for specific home and  
194.5 community-based services under the home and community-based services waivers authorized  
194.6 under Minnesota Statutes, sections 256B.092 and 256B.49.

194.7 (b) The study must include, at minimum, an analysis of the following services:

194.8 (1) employment support services delivered in remote or virtual settings;

194.9 (2) 24-hour emergency assistance;

194.10 (3) assistive technology;

194.11 (4) environmental accessibility adaptations;

194.12 (5) chore services;

194.13 (6) transitional services;

194.14 (7) independent living skills training; and

194.15 (8) specialist services, including positive support services and orientation and mobility  
194.16 services.

194.17 (c) In planning and conducting the market rate study, the commissioner must consult  
194.18 with interested parties, including but not limited to service providers, people with disabilities,  
194.19 lead agencies, Tribal Nations, culturally specific and community-based providers, and  
194.20 disability advocacy organizations. The consultation process must be designed to ensure  
194.21 meaningful participation from providers in greater Minnesota and from providers serving  
194.22 communities of color and Tribal Nations.

194.23 (d) In conducting the study, the commissioner must analyze provider costs, workforce  
194.24 availability, wage competitiveness, regional market conditions, inflationary impacts, and  
194.25 access issues. The commissioner must also evaluate whether current reimbursement  
194.26 methodologies reflect actual costs of providing services and support long-term access to  
194.27 qualified providers.

194.28 (e) By February 15, 2027, the commissioner must submit a report with findings and  
194.29 recommendations, including but not limited to any proposed statutory changes, to the chairs  
194.30 and ranking minority members of the legislative committees with jurisdiction over health  
194.31 and human services policy and finance.

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

195.2 Sec. 41. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**  
195.3 **METHOD OF VISIT VERIFICATION.**

195.4 The commissioner must develop methods for collecting signatures required under  
195.5 Minnesota Statutes, section 256B.073, subdivision 2, paragraph (c), clause (7), of the service  
195.6 recipient, the service recipient's legal guardian or conservator, or the service recipient's  
195.7 parent, if the service recipient is a minor, on a statement acknowledging that providing false  
195.8 information on an electronic visit verification is a federal crime and attesting to the accuracy  
195.9 of the information contained on an electronic visit verification. The methods may differ to  
195.10 meet the needs of the service recipient, the service recipient's legal guardian or conservator,  
195.11 or the service recipient's parent, if the service recipient is a minor.

195.12 Sec. 42. **ELECTRONIC VISIT VERIFICATION AND MEDICAL ASSISTANCE**  
195.13 **CLAIMS VALIDATION.**

195.14 (a) The commissioner of human services must develop, test, and implement systems  
195.15 changes necessary to integrate data collected through electronic visit verification systems,  
195.16 as described under Minnesota Statutes, section 256B.073, with Minnesota's Medicaid  
195.17 Management Information System (MMIS). Data collected through electronic visit verification  
195.18 systems must be used as part of the commissioner's processes for validating claims for  
195.19 services subject to electronic visit verification.

195.20 (b) The commissioner of human services must require that managed care plans and  
195.21 county-based purchasing plans ensure electronic visit verification and claims system  
195.22 interoperability by January 1, 2027.

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

195.24 Sec. 43. **REPEALER.**

195.25 (a) Minnesota Statutes 2024, section 256B.073, subdivision 4, is repealed.

195.26 (b) Minnesota Statutes 2024, section 256B.4914, subdivision 6c, is repealed.

195.27 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2026. Paragraph (b) is effective  
195.28 January 1, 2027, or upon federal approval, whichever is later.

196.1

**ARTICLE 6**

196.2

**HUMAN SERVICES ADMINISTRATIVE REFORM**

196.3

Section 1. Minnesota Statutes 2024, section 16A.103, is amended by adding a subdivision

196.4

to read:

196.5

Subd. 5. **Medical assistance; detailed costs.** (a) In the forecast of state revenues and

196.6

expenditures under subdivision 1, the commissioner must include forecasted costs of each

196.7

covered service provided under medical assistance.

196.8

(b) At the time of delivering the forecast of state revenues and expenditures under

196.9

subdivision 1, the commissioner, in consultation with the commissioner of human services,

196.10

must submit a report to the chairs and ranking minority members of the legislative committees

196.11

with jurisdiction over medical assistance that includes the information required under

196.12

paragraph (a) and identifies the covered services that are mandatory benefits under federal

196.13

law and regulations.

196.14

Sec. 2. Minnesota Statutes 2024, section 256B.05, subdivision 1, is amended to read:

196.15

Subdivision 1. **Administration of medical assistance.** (a) The county agencies shall

196.16

administer medical assistance in their respective counties under the supervision of the state

196.17

agency and the commissioner of human services as specified in section 256.01, and shall

196.18

make such reports, prepare such statistics, and keep such records and accounts in relation

196.19

to medical assistance as the state agency may require under section 256.01, subdivision 2,

196.20

paragraph (o).

196.21

(b) The commissioner may administer specific duties related to determining medical

196.22

assistance eligibility on behalf of county agency administrations to ensure compliance with

196.23

federal and state requirements for the medical assistance program. If the commissioner

196.24

elects to assume specific duties under this paragraph, the commissioner must undertake the

196.25

assumed duties on a statewide and uniform administrative and operational basis.

196.26

Sec. 3. **DIRECTION TO COMMISSIONER; TRANSFER ASSESSMENT.**

196.27

(a) The commissioner of human services must procure a contract with a vendor to assess

196.28

the current status of administration of medical assistance and plan for a transfer of

196.29

administration of medical assistance to the commissioner by January 1, 2033. The

196.30

commissioner must submit the assessment and plan to the chairs and ranking minority

196.31

members of the legislative committees with jurisdiction over human services and health

196.32

care policy and finance by October 1, 2028.

197.1 (b) The assessment and plan must include:

197.2 (1) a comprehensive assessment of medical assistance eligibility functions performed  
197.3 by counties and Tribal governments, including identification of handoffs between county  
197.4 and Tribal eligibility workers and state eligibility workers, and a catalog of eligibility  
197.5 functions performed by state eligibility workers;

197.6 (2) examination of current expenditures, administrative budgets, and federal financial  
197.7 participation in county and Tribal administrative work related to medical assistance eligibility  
197.8 activities;

197.9 (3) eligibility system review, mapping, and recommended updates; and

197.10 (4) recommendations for a successful transition of centralized eligibility functions based  
197.11 on consultation with stakeholders, review of information provided by county and Tribal  
197.12 governments, review of other states' best practices for maximizing federal dollars, a feasible  
197.13 timeline of activities, and required legislative changes and actions.

197.14 (c) The commissioner must consult with Minnesota's Tribal Nations, the Association of  
197.15 Minnesota Counties, and the Minnesota Association of County Social Service Administrators  
197.16 on the final deliverables included in the assessment.

197.17 **Sec. 4. DIRECTION TO COMMISSIONER; ASSESSMENT OF ADMINISTRATIVE**  
197.18 **ROLES.**

197.19 (a) The commissioners of human services and children, youth, and families, in  
197.20 consultation with Minnesota's Tribal Nations and counties, must conduct a study to assess  
197.21 and recommend improvements to the roles and responsibilities of the Departments of Human  
197.22 Services and Children, Youth, and Families, the counties, and Minnesota's Tribal Nations  
197.23 in administering human services programs.

197.24 (b) The study must include a comprehensive review of programs administered by the  
197.25 departments, including but not limited to medical assistance, MinnesotaCare, behavioral  
197.26 health services, long-term services and supports, housing and homelessness programs,  
197.27 Minnesota supplemental aid, general assistance, economic assistance, child support, child  
197.28 care and early learning, and licensing and oversight functions.

197.29 (c) The study must evaluate the:

197.30 (1) current roles and responsibilities held by the departments, the counties, and  
197.31 Minnesota's Tribal Nations in administering human services programs, including but not  
197.32 limited to the challenges and benefits of the current delegation of roles and responsibilities;

198.1 (2) lived experience of people accessing human services programs related to the  
198.2 delegation of administrative duties;

198.3 (3) financing of human services program administration across the departments, the  
198.4 counties, and Minnesota's Tribal Nations; and

198.5 (4) administration of human services programs in other states, focusing on the roles and  
198.6 responsibilities of the local governments versus the state Medicaid or human services agency,  
198.7 and identifying the benefits, challenges, and financing of the delegation of duties.

198.8 (d) The study must focus on the goals of transforming the human services system to  
198.9 ensure a transparent, accessible, accountable, equitable, and effective human services system.

198.10 (e) The study must provide recommendations for the optimal delegation of duties between  
198.11 the departments, the counties, and Minnesota's Tribal Nations in the delivery of human  
198.12 services. Recommendations must include:

198.13 (1) how the delegation of duties will improve the experience of people accessing human  
198.14 services;

198.15 (2) implementation and timing considerations to ensure continuity of services;

198.16 (3) systems technology adaptations required;

198.17 (4) workforce considerations; and

198.18 (5) financing strategies and the estimated fiscal impact to the state budget.

198.19 (f) Notwithstanding Minnesota Statutes, chapter 13, or other statutes or rules to the  
198.20 contrary, counties must provide financial, human resources, and other information necessary  
198.21 to complete the study in the form and manner and on the timeline requested by the  
198.22 commissioners.

198.23 (g) By October 1, 2028, the commissioners must submit a report on the study and  
198.24 recommendations to the chairs and ranking minority members of the legislative committees  
198.25 with jurisdiction over health; human services; and children, youth, and families policy and  
198.26 finance.

198.27 **Sec. 5. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**  
198.28 **EVALUATION OF DHS STRUCTURE AND PROCESSES.**

198.29 (a) The commissioner of human services must contract with an external consultant to  
198.30 continue and complete the project initiated under Executive Order 25-10, section 1, paragraph  
198.31 (g), to make recommendations to improve the Department of Human Services' performance

199.1 as the state's Medicaid agency. The external consultant must evaluate the department's  
199.2 structure and processes and assess the adequacy of the department's current policies,  
199.3 procedures, systems, organizational structure, staffing levels, and funding to effectively  
199.4 increase program integrity, minimize fraud, and more effectively serve as the state's Medicaid  
199.5 agency.

199.6 (b) By October 1, 2026, the commissioner must submit a report to the chairs and ranking  
199.7 minority members of the legislative committees with jurisdiction over health and human  
199.8 services policy and finance. The report must include information on the recommendations  
199.9 of the external contractor made through September 30, 2026, and any actions the  
199.10 commissioner has taken in response to the external contractor's recommendations or other  
199.11 actions taken by the commissioner pursuant to Executive Order 25-10, section 1, paragraph  
199.12 (g), through September 30, 2026.

199.13 (c) By October 1, 2027, the commissioner must submit a summary of the  
199.14 recommendations of the external contractor with whom the commissioner contracted under  
199.15 Executive Order 25-10, section 1, paragraph (g), and any actions the commissioner has  
199.16 taken in response to either the external contractor's recommendations or other actions taken  
199.17 by the commissioner pursuant to Executive Order 25-10, section 1, paragraph (g). The  
199.18 summary must be submitted to the chairs and ranking minority members of the legislative  
199.19 committees with jurisdiction over health and human services policy and finance.

199.20 (d) By October 1, 2028, the commissioner must submit the external consultant's report  
199.21 summarizing the evaluation and recommendations to the chairs and ranking minority  
199.22 members of the legislative committees with jurisdiction over health and human services  
199.23 policy and finance. The commissioner must also submit draft legislative language to  
199.24 implement the recommendations of the external consultant's recommendations.

## ARTICLE 7

### CHILDREN, YOUTH, AND FAMILIES

199.27 Section 1. Minnesota Statutes 2024, section 142E.16, is amended by adding a subdivision  
199.28 to read:

199.29 Subd. 1a. **Training required for payments.** (a) As a condition of payment and prior to  
199.30 authorization, all providers receiving child care assistance payments must complete  
199.31 compliance training developed by the commissioner that addresses program integrity  
199.32 requirements including but not limited to record keeping and billing requirements. The

200.1 commissioner shall develop criteria, reporting requirements, and standards for when providers  
200.2 need to renew training after their initial registration.

200.3 (b) Providers that do not have an active registration to receive child care assistance on  
200.4 or before April 12, 2027, must complete the training under this subdivision prior to  
200.5 authorization. Providers with an active registration on or before April 12, 2027, must  
200.6 complete the training under this subdivision before the provider's first renewal after April  
200.7 12, 2027, or April 10, 2028, whichever is later.

## 200.8 ARTICLE 8

### 200.9 MISCELLANEOUS

200.10 Section 1. Minnesota Statutes 2024, section 245.096, is amended to read:

#### 200.11 **245.096 CHANGES TO GRANT PROGRAMS.**

200.12 Prior to implementing any ~~substantial~~ changes to a grant funding formula disbursed  
200.13 through allocations administered by the commissioner, the commissioner must provide a  
200.14 report on the nature of the changes, the effect the changes will have, whether any funding  
200.15 will change, and other relevant information, to the chairs and ranking minority members of  
200.16 the legislative committees with jurisdiction over human services. The report must be provided  
200.17 prior to the start of a regular session, and the proposed changes cannot be implemented until  
200.18 after the adjournment of that regular session.

#### 200.19 Sec. 2. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;** 200.20 **CODIFYING THE OFFICE OF INSPECTOR GENERAL.**

200.21 (a) By December 1, 2026, the commissioner of human services must provide statutory  
200.22 language that codifies the Department of Human Services Office of Inspector General to  
200.23 the chairs and ranking minority members of the legislative committees with jurisdiction  
200.24 over human services and the nonpartisan staff from House Research Department and Senate  
200.25 Counsel, Research, and Fiscal Analysis whose drafting areas include human services. The  
200.26 statutory language must only contain:

200.27 (1) existing legal authority identified by the office that the office relies upon to carry  
200.28 out its duties; and

200.29 (2) policies and procedures necessary for the office to carry out its existing duties.

200.30 (b) The commissioner must not include desired policy changes to the office, its structure,  
200.31 or its duties within the codification language required under paragraph (a).

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

201.2 **ARTICLE 9**

201.3 **DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS**

201.4 Section 1. **HUMAN SERVICES APPROPRIATIONS.**

201.5 The sums shown in the columns marked "Appropriations" are added to or, if shown in  
201.6 parentheses, are subtracted from the appropriations in Laws 2025, First Special Session  
201.7 chapter 3, article 20, and Laws 2025, First Special Session chapter 9, article 12, to the agency  
201.8 and for purposes specified in this article. The appropriations are from the general fund or  
201.9 other named fund and are available for the fiscal years indicated for each purpose. The  
201.10 figures "2026" and "2027" used in this article mean that the addition to or subtraction from  
201.11 the appropriation listed under them is available for the fiscal year ending June 30, 2026, or  
201.12 June 30, 2027, respectively. Base adjustments mean the addition to or subtraction from the  
201.13 base level adjustment set in Laws 2025, First Special Session chapter 3, article 20, and Laws  
201.14 2025, First Special Session chapter 9, article 12. Appropriations and reductions to  
201.15 appropriations for the fiscal year ending June 30, 2026, are effective the day following final  
201.16 enactment unless a different effective date is explicit.

201.17		<b><u>APPROPRIATIONS</u></b>	
201.18		<b><u>Available for the Year</u></b>	
201.19		<b><u>Ending June 30</u></b>	
201.20		<b><u>2026</u></b>	<b><u>2027</u></b>
201.21	<b><u>Sec. 2. COMMISSIONER OF HUMAN</u></b>		
201.22	<b><u>SERVICES</u></b>	<b><u>\$</u></b>	<b><u>-0-</u></b> <b><u>\$</u></b> <b><u>(95,072,000)</u></b>

201.23	<b><u>Appropriations by Fund</u></b>		
201.24		<b><u>2026</u></b>	<b><u>2027</u></b>
201.25	<b><u>General</u></b>	<b><u>-0-</u></b>	<b><u>(97,085,000)</u></b>
201.26	<b><u>Special Government</u></b>		
201.27	<b><u>Revenue Fund</u></b>	<b><u>-0-</u></b>	<b><u>2,013,000</u></b>

201.28 The amounts that may be spent for each  
201.29 purpose are specified in the following sections  
201.30 and subdivisions.

201.31	<b><u>Sec. 3. CENTRAL OFFICE; OPERATIONS</u></b>	<b><u>\$</u></b>	<b><u>-0-</u></b> <b><u>\$</u></b> <b><u>30,611,000</u></b>
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201.32 **Subdivision 1. Assessment of Roles in**  
201.33 **Administering Human Services Programs**

201.34 \$3,000,000 in fiscal year 2027 is for an  
201.35 assessment of the administrative roles and

202.1 responsibilities of the state agency, counties,  
202.2 and Tribal Nations administering human  
202.3 services programs. This is a onetime  
202.4 appropriation and is available until June 30,  
202.5 2029.

202.6 **Subd. 2. Prepayment Review Vendor Contract**

202.7 \$2,500,000 in fiscal year 2027 is for a  
202.8 competitively awarded contract to establish  
202.9 ongoing prepayment claims analysis  
202.10 technology for services provided under  
202.11 medical assistance. This is a onetime  
202.12 appropriation.

202.13 **Subd. 3. Prepayment Review Technology**  
202.14 **Contract**

202.15 \$3,750,000 in fiscal year 2027 is for a  
202.16 competitively awarded vendor contract to  
202.17 support prepayment review technology to  
202.18 build on and reference existing claims edits  
202.19 infrastructure, prior authorization criteria, and  
202.20 continuous refining of the prepayment review  
202.21 analytic module to automate fraud detection  
202.22 and payment integrity based on findings over  
202.23 time.

202.24 **Subd. 4. Base Level Adjustment**

202.25 The general fund base is increased by  
202.26 \$22,087,000 in fiscal year 2028 and increased  
202.27 by \$20,406,000 in fiscal year 2029.

202.28 **Sec. 4. CENTRAL OFFICE; HEALTH CARE \$ -0- \$ 10,411,000**

202.29 **Subdivision 1. Medical Assistance Eligibility**  
202.30 **Study**

202.31 \$2,000,000 in fiscal year 2027 is for a study  
202.32 on the transfer of eligibility functions of the  
202.33 medical assistance program performed by  
202.34 county and Tribal governments to the





**ARTICLE 10**

**DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES APPROPRIATIONS**

**Section 1. CHILDREN, YOUTH, AND FAMILIES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2025, First Special Session chapter 3, article 22, to the agency and for purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2025, First Special Session chapter 3, article 22. Appropriations and reductions to appropriations for the fiscal year ending June 30, 2026, are effective the day following final enactment unless a different effective date is explicit.

<b><u>APPROPRIATIONS</u></b>	
<b><u>Available for the Year</u></b>	
<b><u>Ending June 30</u></b>	
<b><u>2026</u></b>	<b><u>2027</u></b>

<b>Sec. 2. <u>COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES</u></b>	<b>\$</b>	<b><u>-0-</u></b>	<b>\$</b>	<b><u>7,208,000</u></b>
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<b>Sec. 3. <u>OPERATIONS AND ADMINISTRATION; AGENCY-WIDE SUPPORTS</u></b>	<b>\$</b>	<b><u>-0-</u></b>	<b>\$</b>	<b><u>5,777,000</u></b>
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**Subdivision 1. Analysis of Governance Roles for DCYF Programs**

\$2,500,000 in fiscal year 2027 is for a study to analyze the governance roles for DCYF programs. This is a onetime appropriation.

**Subd. 2. Base Level Adjustment**

The general fund base is increased by \$3,012,000 in fiscal year 2028 and \$3,013,000 in fiscal year 2029.

<b>Sec. 4. <u>OPERATIONS AND ADMINISTRATION; EARLY CHILDHOOD</u></b>	<b>\$</b>	<b><u>-0-</u></b>	<b>\$</b>	<b><u>612,000</u></b>
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**Base Level Adjustment**



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ARTICLE 6	HUMAN SERVICES ADMINISTRATIVE REFORM.....	Page.Ln 196.1
ARTICLE 7	CHILDREN, YOUTH, AND FAMILIES.....	Page.Ln 199.25
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**245.735 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES.**

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

(b) "Alcohol and drug counselor" has the meaning given in section 245G.11, subdivision 5.

(c) "Care coordination" means the activities required to coordinate care across settings and providers for a person served to ensure seamless transitions across the full spectrum of health services. Care coordination includes outreach and engagement; documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan; assisting with obtaining appointments; confirming appointments are kept; developing a crisis plan; tracking medication; and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation with primary care practitioners and with mental health clinical care practitioners.

(d) "Community needs assessment" means an assessment to identify community needs and determine the community behavioral health clinic's capacity to address the needs of the population being served.

(e) "Comprehensive evaluation" means a person-centered, family-centered, and trauma-informed evaluation meeting the requirements of subdivision 4b completed for the purposes of diagnosis and treatment planning.

(f) "Designated collaborating organization" means an entity meeting the requirements of subdivision 3a with a formal agreement with a CCBHC to furnish CCBHC services.

(g) "Functional assessment" means an assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age and that meets the requirements of subdivision 4a.

(h) "Initial evaluation" means an evaluation completed by a mental health professional that gathers and documents information necessary to formulate a preliminary diagnosis and begin client services.

(i) "Integrated treatment plan" means a documented plan of care that is person- and family-centered and formulated to respond to a client's needs and goals.

(j) "Mental health professional" has the meaning given in section 245I.04, subdivision 2.

(k) "Mobile crisis services" has the meaning given in section 256B.0624, subdivision 2.

(l) "Preliminary screening and risk assessment" means a mandatory screening and risk assessment that is completed at the first contact with the prospective CCBHC service recipient and determines the acuity of client need.

Subd. 2a. **Establishment.** The certified community behavioral health clinic model is an integrated payment and service delivery model that uses evidence-based behavioral health practices to achieve better outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates for providers and economic efficiencies for payors.

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish state certification and recertification processes for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification or recertification process and requirements. Any changes to the certification or recertification process or requirements must be consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration. The commissioner must allow a transition period for CCBHCs to meet the revised criteria on or before January 1, 2025. The commissioner is authorized to amend the state's Medicaid state plan or the terms of the demonstration to comply with federal requirements.

(b) As part of the state CCBHC certification and recertification processes, the commissioner shall provide to entities applying for certification or requesting recertification the standard requirements of the community needs assessment and the staffing plan that are consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

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(c) The commissioner shall schedule a certification review that includes a site visit within 90 calendar days of receipt of an application for certification or recertification.

(d) Entities that choose to be CCBHCs must:

(1) complete a community needs assessment and complete a staffing plan that is responsive to the needs identified in the community needs assessment and update both the community needs assessment and the staffing plan no less frequently than every 36 months;

(2) comply with state licensing requirements and other requirements issued by the commissioner;

(3) employ or contract with a medical director. A medical director must be a physician licensed under chapter 147 and either certified by the American Board of Psychiatry and Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible for board certification in psychiatry. A registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization may serve as the medical director when a CCBHC is unable to employ or contract a qualified physician;

(4) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(5) ensure that clinic services are available and accessible to individuals and families of all ages and genders with access on evenings and weekends and that crisis management services are available 24 hours per day;

(6) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(7) comply with quality assurance reporting requirements and other reporting requirements included in the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration;

(8) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to subdivision 3a;

(9) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs;

(10) be certified as a mental health clinic under section 245I.20;

(11) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations that are consistent with this section;

(12) be licensed to provide substance use disorder treatment under chapter 245G;

(13) be certified to provide children's therapeutic services and supports under section 256B.0943;

(14) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(15) be enrolled to provide mental health crisis response services under section 256B.0624;

(16) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(17) provide services that comply with the evidence-based practices described in subdivision 3d;

(18) provide peer services as defined in sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2), as applicable when peer services are provided; and

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(19) inform all clients upon initiation of care of the full array of services available under the CCBHC model.

Subd. 3a. **Designated collaborating organizations.** If a certified CCBHC is unable to provide one or more of the services listed in subdivision 3, paragraph (d), clauses (8) to (19), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the requirements of the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

Subd. 3b. **Exemptions to host county approval.** Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Subd. 3c. **Variances.** When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders before granting variances under this provision. For a CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Subd. 3d. **Evidence-based practices.** The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

Subd. 3e. **Recertification.** A CCBHC must apply for recertification every 36 months.

Subd. 3f. **Notice and opportunity for correction.** (a) The commissioner shall provide a formal written notice to an applicant for CCBHC certification outlining the determination of the application and process for applicable and necessary corrective action required of the applicant signed by the commissioner or appropriate division director to applicant entities within 45 calendar days of the site visit.

(b) The commissioner may reject an application if the applicant entity does not take all corrective actions specified in the notice and notify the commissioner that the applicant entity has done so within 60 calendar days.

(c) The commissioner must send the applicant entity a final decision on the corrected application within 45 calendar days of the applicant entity's notice to the commissioner that the applicant has taken the required corrective actions.

Subd. 3g. **Decertification process.** The commissioner must establish a process for decertification. The commissioner must require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application, certification, or recertification process.

Subd. 3h. **Minimum staffing standards.** A CCBHC must meet minimum staffing requirements required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

Subd. 4a. **Functional assessment requirements.** (a) For adults, a functional assessment may be completed using a Daily Living Activities-20 tool.

(b) Notwithstanding any law to the contrary, a functional assessment performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 256B.0623, subdivision 9;
- (2) section 245.4711, subdivision 3; and

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(3) Minnesota Rules, part 9520.0914, subpart 2.

**Subd. 4b. Requirements for comprehensive evaluations.** (a) A comprehensive evaluation must be completed for all new clients within 60 calendar days following the preliminary screening and risk assessment.

(b) Only a mental health professional may complete a comprehensive evaluation. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate.

(c) The comprehensive evaluation must consist of the synthesis of existing information including but not limited to an external diagnostic assessment, crisis assessment, preliminary screening and risk assessment, initial evaluation, and primary care screenings.

(d) A comprehensive evaluation must be completed in the cultural context of the client and updated to reflect changes in the client's conditions and at the client's request or when the client's condition no longer meets the existing diagnosis.

(e) The psychiatric evaluation and management service fulfills requirements for the comprehensive evaluation when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC shall complete the comprehensive evaluation within 60 calendar days of a client's referral for additional CCBHC services.

(f) For clients engaging exclusively in substance use disorder services at the CCBHC, a substance use disorder comprehensive assessment as defined in section 245G.05, subdivision 2, that is completed within 60 calendar days of service initiation shall fulfill requirements of the comprehensive evaluation.

(g) Notwithstanding any law to the contrary, a comprehensive evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 245.462, subdivision 20, paragraph (c);
- (2) section 245.4711, subdivision 2, paragraph (b);
- (3) section 245.4871, subdivision 6;
- (4) section 245.4881, subdivision 2, paragraph (c);
- (5) section 245G.04, subdivision 1;
- (6) section 245G.05, subdivision 1;
- (7) section 245I.10, subdivisions 4 to 6;
- (8) section 256B.0623, subdivisions 3, clause (4), 8, and 10;
- (9) section 256B.0943, subdivisions 3 and 6, paragraph (b), clause (1);
- (10) Minnesota Rules, part 9520.0909, subpart 1;
- (11) Minnesota Rules, part 9520.0910, subparts 1 and 2; and
- (12) Minnesota Rules, part 9520.0914, subpart 2.

**Subd. 4c. Requirements for initial evaluations.** (a) A CCBHC must complete either an initial evaluation or a comprehensive evaluation as required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(b) Notwithstanding any law to the contrary, an initial evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 245.4711, subdivision 4;
- (2) section 245.4881, subdivisions 3 and 4;
- (3) section 245I.10, subdivision 5;
- (4) section 256B.0623, subdivisions 3, clause (4), 8, and 10;
- (5) section 256B.0943, subdivisions 3 and 6, paragraph (b), clauses (1) and (2);
- (6) Minnesota Rules, part 9520.0909, subpart 1;

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- (7) Minnesota Rules, part 9520.0910, subpart 1;
- (8) Minnesota Rules, part 9520.0914, subpart 2;
- (9) Minnesota Rules, part 9520.0918, subparts 1 and 2; and
- (10) Minnesota Rules, part 9520.0919, subpart 2.

Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment plan must be completed within 60 calendar days following the preliminary screening and risk assessment and updated no less frequently than every six months or when the client's circumstances change.

(b) Only a mental health professional may complete an integrated treatment plan. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate. An alcohol and drug counselor may approve the integrated treatment plan. The integrated treatment plan must be developed through a shared decision-making process with the client, the client's support system if the client chooses, or, for children, with the family or caregivers.

(c) The integrated treatment plan must:

- (1) use the ASAM 6 dimensional framework; and
- (2) incorporate prevention, medical and behavioral health needs, and service delivery.

(d) The psychiatric evaluation and management service fulfills requirements for the integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC must complete an integrated treatment plan within 60 calendar days of a client's referral for additional CCBHC services.

(e) Notwithstanding any law to the contrary, an integrated treatment plan developed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

- (1) section 245G.06, subdivision 1;
- (2) section 245G.09, subdivision 3, paragraph (a), clause (6);
- (3) section 245I.10, subdivisions 7 and 8; and
- (4) section 256B.0943, subdivision 6, paragraph (b), clause (2).

Subd. 4e. **Additional licensing and certification requirements.** (a) This subdivision applies to programs and clinics that are a part of a CCBHC.

(b) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the licensing requirements for substance use disorder treatment programs under chapter 245G.

(c) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the certification requirements for mental health clinics under section 245I.20.

(d) The Department of Human Services licensing division will review, inspect, and investigate for compliance with the requirements in subdivisions 4b to 4d for programs or clinics subject to this subdivision.

Subd. 7. **Addition of CCBHCs to section 223 state demonstration programs.** (a) If the commissioner's request under subdivision 6 to reenter the demonstration program established by section 223 of the Protecting Access to Medicare Act is approved, upon reentry the commissioner must follow all federal guidance on the addition of CCBHCs to section 223 state demonstration programs.

(b) Prior to participating in the demonstration, a CCBHC must meet the demonstration certification criteria and prospective payment system guidance in effect at that time and be certified as a CCBHC by the state. The Substance Abuse and Mental Health Services Administration attestation process for CCBHC expansion grants is not sufficient to constitute state certification. CCBHCs newly added to the demonstration must participate in all aspects of the state demonstration program, including but not limited to quality measurement and reporting, evaluation activities, and state CCBHC demonstration program requirements, such as use of state-specified evidence-based practices. A newly added CCBHC must report on quality measures before its first full demonstration year if it joined the demonstration program in calendar year 2023 out of alignment with the state's

demonstration year cycle. A CCBHC may provide services in multiple locations and in community-based settings subject to federal rules of the 223 demonstration authority or Medicaid state plan authority.

(c) If a CCBHC meets the definition of a satellite facility, as defined by the Substance Abuse and Mental Health Services Administration, and was established after April 1, 2014, the CCBHC cannot receive payment as a part of the demonstration program.

Subd. 8. **Grievance procedures required.** CCBHCs and designated collaborating organizations must allow all service recipients access to grievance procedures, which must satisfy the minimum requirements of medical assistance and other grievance requirements such as those that may be mandated by relevant accrediting entities.

#### **245A.042 HOME AND COMMUNITY-BASED SERVICES; ADDITIONAL STANDARDS AND PROCEDURES.**

Subd. 5. **Compliance education required.** The commissioner must make licensing compliance education available to all license holders operating programs licensed under both this chapter and chapter 245D. The licensing compliance education must include clear and accessible explanations of achieving and maintaining compliance with the relevant licensing requirements under this chapter and chapter 245D.

#### **245A.10 FEES.**

Subd. 3a. **Fee for change of ownership exception.** (a) A license holder must submit a fee of \$2,100 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(b) License holders under chapter 245D must submit a fee of \$4,200 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(c) A license holder for a children's residential facility must submit a fee of \$500 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

#### **245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.**

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies of all direct service providers and volunteers for children's therapeutic services and supports providers under section 256B.0943.

#### **245I.20 MENTAL HEALTH CLINIC.**

Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification holder must develop a written quality assurance and improvement plan that includes a plan for:

- (1) encouraging ongoing consultation among members of the treatment team;
- (2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;
- (3) measuring and evaluating client outcomes;
- (4) reviewing client suicide deaths and suicide attempts;
- (5) examining the quality of clinical service delivery to clients; and
- (6) self-monitoring of compliance with this chapter.

(b) At least annually, the certification holder must review, evaluate, and update the quality assurance and improvement plan. The review must: (1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and (2) establish goals for improved service delivery to clients for the next year.

#### **245I.23 INTENSIVE RESIDENTIAL TREATMENT SERVICES AND RESIDENTIAL CRISIS STABILIZATION.**

Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop a written quality assurance and improvement plan that includes a plan to:

- (1) encourage ongoing consultation between members of the treatment team;

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(2) obtain and evaluate feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measure and evaluate client outcomes in the program;

(4) review critical incidents in the program;

(5) examine the quality of clinical services in the program; and

(6) self-monitor the license holder's compliance with this chapter.

(b) At least annually, the license holder must review, evaluate, and update the license holder's quality assurance and improvement plan. The license holder's review must:

(1) document the actions that the license holder will take in response to the information that the license holder obtains from the monitoring activities in the plan; and

(2) establish goals for improving the license holder's services to clients during the next year.

**256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.**

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means the services described in section 245I.02, subdivision 33.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) State-level recertification must occur at least every three years.

(d) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(e) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train qualified staff;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure that staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with

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the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

(7) keep all necessary records required by law;

(8) deliver services as required by section 245.461;

(9) be an enrolled Medicaid provider; and

(10) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services.

**Subd. 5. Qualifications of provider staff.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified as:

(1) a mental health professional who is qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist who is qualified according to section 245I.04, subdivision 8;

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

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

(5) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

(6) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14; or

(7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

**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) 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) 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;

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- (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.

Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health services must complete a written functional assessment according to section 245I.10, subdivision 9, for each recipient.

(b) When a provider of adult rehabilitative mental health services completes a written functional assessment, the provider must also complete a level of care assessment as defined in section 245I.02, subdivision 19, for the recipient.

**256B.0624 CRISIS RESPONSE SERVICES COVERED.**

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Certified rehabilitation specialist" means a staff person who is qualified under section 245I.04, subdivision 8.

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or a qualified member of a crisis team, as described in subdivision 6a.

(d) "Crisis intervention" means face-to-face, short-term intensive mental health services initiated during a mental health crisis to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning.

(e) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

(f) "Crisis stabilization" means individualized mental health services provided to a recipient that are designed to restore the recipient to the recipient's prior functional level. Crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, a short-term supervised, licensed residential program, or an emergency department. Crisis stabilization services includes family psychoeducation.

(g) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

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

(i) "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

(j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient's levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.

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

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

(m) "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

(n) "Mobile crisis services" means screening, assessment, intervention, and community-based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

Subd. 3. **Eligibility.** (a) A recipient is eligible for crisis assessment services when the recipient has screened positive for a potential mental health crisis during a crisis screening.

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(b) A recipient is eligible for crisis intervention services and crisis stabilization services when the recipient has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4a. **Alternative provider standards.** If a county or Tribe demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph (b), the commissioner may approve an alternative plan proposed by a county or Tribe. The alternative plan must:

- (1) result in increased access and a reduction in disparities in the availability of mobile crisis services;
- (2) provide mobile crisis services outside of the usual nine-to-five office hours and on weekends and holidays; and
- (3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

- (1) mental health professional;
- (2) clinical trainee;
- (3) mental health practitioner;
- (4) mental health certified family peer specialist; or
- (5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

- (1) developmental tasks of childhood and adolescence;
- (2) family relationships;
- (3) child and youth engagement and motivation, including motivational interviewing;
- (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;
- (5) positive behavior support;
- (6) crisis intervention for youth with developmental disabilities;
- (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and
- (8) youth substance use.

(e) Team members must be experienced in crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources.

Subd. 6. **Crisis screening.** (a) The crisis screening may use the resources of emergency services as defined in section 245.469, subdivisions 1 and 2. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting the crisis screening of a recipient, a provider must:

- (1) employ evidence-based practices to reduce the recipient's risk of suicide and self-injurious behavior;

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(2) work with the recipient to establish a plan and time frame for responding to the recipient's mental health crisis, including responding to the recipient's immediate need for support by telephone or text message until the provider can respond to the recipient face-to-face;

(3) document significant factors in determining whether the recipient is experiencing a mental health crisis, including prior requests for crisis services, a recipient's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of a recipient's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including means reduction, to relevant third parties including family members or other persons living with the recipient; and

(6) consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis and the provider must prioritize providing a face-to-face crisis assessment of the recipient, unless a provider documents specific evidence to show why this was not possible, including insufficient staffing resources, concerns for staff or recipient safety, or other clinical factors:

(1) the recipient presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the recipient to determine that the recipient is experiencing a potential mental health crisis. A mobile crisis provider may gather relevant information about the recipient from a third party to establish the recipient's need for services and potential safety factors.

Subd. 6a. **Crisis assessment.** (a) If a recipient screens positive for a potential mental health crisis, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which services are needed and, as time permits, the recipient's current life situation, health information, including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described under subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the recipient's location whenever possible.

(c) Whenever possible, the assessor must attempt to include input from the recipient and the recipient's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes: (1) determining (i) whether the recipient is willing to voluntarily engage in treatment, or (ii) whether the recipient has an advance directive, and (2) gathering the recipient's information and history from involved family or other natural supports.

(e) A crisis assessment must include coordinated response with other health care providers if the assessment indicates that a recipient needs detoxification, withdrawal management, or medical stabilization in addition to crisis response services. If the recipient does not need an acute level of care, a team must serve an otherwise eligible recipient who has a co-occurring substance use disorder.

(f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the recipient's crisis assessment must immediately contact the referral entity and consult with the triage nurse or other staff responsible for intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the recipient's referral. Following the immediate consultation, the provider must also send written documentation upon completion. The provider must document if these releases occurred with authorization by the recipient, the recipient's legal guardian, or as allowed by section 144.293, subdivision 5.

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**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.

**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.

(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 establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider for the same service to other payers. Payment shall not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The commissioner shall recalculate the statewide per diem every year.

**Subd. 8. Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) mental health professional;

(2) certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner;

(5) mental health certified family peer specialist;

(6) mental health certified peer specialist; or

(7) mental health rehabilitation worker.

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(b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

(c) For providers who deliver care to children 21 years of age and younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children and include the following topics:

- (1) developmental tasks of childhood and adolescence;
- (2) family relationships;
- (3) child and youth engagement and motivation, including motivational interviewing;
- (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;
- (5) positive behavior support;
- (6) crisis intervention for youth with developmental disabilities;
- (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and
- (8) youth substance use.

This paragraph does not apply to adult residential crisis stabilization service providers licensed according to section 245I.23.

**Subd. 9. Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and crisis intervention services if the following treatment supervision requirements are met:

- (1) the mental health provider entity must accept full responsibility for the services provided;
- (2) the mental health professional of the provider entity must be immediately available by phone or in person for treatment supervision;
- (3) the mental health professional is consulted, in person or by phone, during the first three hours when a clinical trainee or mental health practitioner provides crisis assessment or crisis intervention services; and
- (4) the mental health professional must:
  - (i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the recipient, notwithstanding section 245I.08, subdivision 3; and
  - (ii) document the consultation required in clause (3).

**Subd. 11. Crisis treatment plan.** (a) Within 24 hours of the recipient's admission, the provider entity must complete the recipient's crisis treatment plan. The provider entity must:

- (1) base the recipient's crisis treatment plan on the recipient's crisis assessment;
- (2) consider crisis assistance strategies that have been effective for the recipient in the past;
- (3) for a child recipient, use a child-centered, family-driven, and culturally appropriate planning process that allows the recipient's parents and guardians to observe or participate in the recipient's individual and family treatment services, assessment, and treatment planning;
- (4) for an adult recipient, use a person-centered, culturally appropriate planning process that allows the recipient's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;
- (5) identify the participants involved in the recipient's treatment planning. The recipient, if possible, must be a participant;
- (6) identify the recipient's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the recipient engage in treatment;

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(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the recipient or the recipient's legal guardian approves under section 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the recipient disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of the recipient's treatment plan within 24 hours of the recipient's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the recipient and the recipient's legal guardian with a copy of the recipient's crisis treatment plan.

**256B.073 ELECTRONIC VISIT VERIFICATION.**

Subd. 4. **Provider requirements.** (a) A provider of services may select any electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by a date established by the commissioner to be set after the state-selected electronic visit verification systems for personal care services and home health services are in production. For purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(1)(5). Reimbursement rates for providers must not be reduced as a result of federal action to reduce the federal medical assistance percentage under the 21st Century Cures Act, Public Law 114-255.

**256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

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 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.

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(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.

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis planning. The commissioner shall recertify a provider entity every three years using the individual provider's certification anniversary or the calendar year end, whichever is later. The commissioner may approve a recertification extension, in the interest of sustaining services, when a certain date for recertification is identified. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical

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assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) The commissioner must provide the following to providers for the certification, recertification, and decertification processes:

(1) a structured listing of required provider certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification, signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner, if applicable.

(c) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required under section 245I.011, subdivision 5, and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

**Subd. 5. Provider entity administrative infrastructure requirements.** (a) An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence.

(b) In addition to the policies and procedures required under section 245I.03, the policies and procedures must include:

(1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

(2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals.

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

**Subd. 5a. Background studies.** The requirements for background studies under section 245I.011, subdivision 5, paragraph (b), may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

**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 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;

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(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.

**Subd. 7. Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health behavioral aide.

(c) A day treatment team must include one mental health professional or clinical trainee.

**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

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determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of three to eight clients; or

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

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

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

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

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

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with 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.

**Subd. 11. Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner.

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Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

(b) Required documentation must be completed for each individual provider and service modality for each day a child receives a service under subdivision 2, paragraph (b).

**256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.**

Subd. 6c. **Integrated community supports; component values and calculation of payment rates.** (a) Component values for integrated community supports are:

- (1) competitive workforce factor: 6.7 percent;
- (2) supervisory span of control ratio: 11 percent;
- (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
- (4) employee-related cost ratio: 23.6 percent;
- (5) general administrative support ratio: 13.25 percent;
- (6) program-related expense ratio: 1.3 percent; and
- (7) absence and utilization factor ratio: 3.9 percent.

(b) Payments for integrated community supports must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs. The base shared direct staffing hours must be eight hours divided by the number of people receiving support in the integrated community support setting, and the individual direct staffing hours must be the average number of direct support hours provided directly to the service recipient;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours in clause (1) by the appropriate staff wages;

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

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

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

(9) for client programming and supports, add \$2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) add the results of clauses (8) and (9);

(11) add the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.